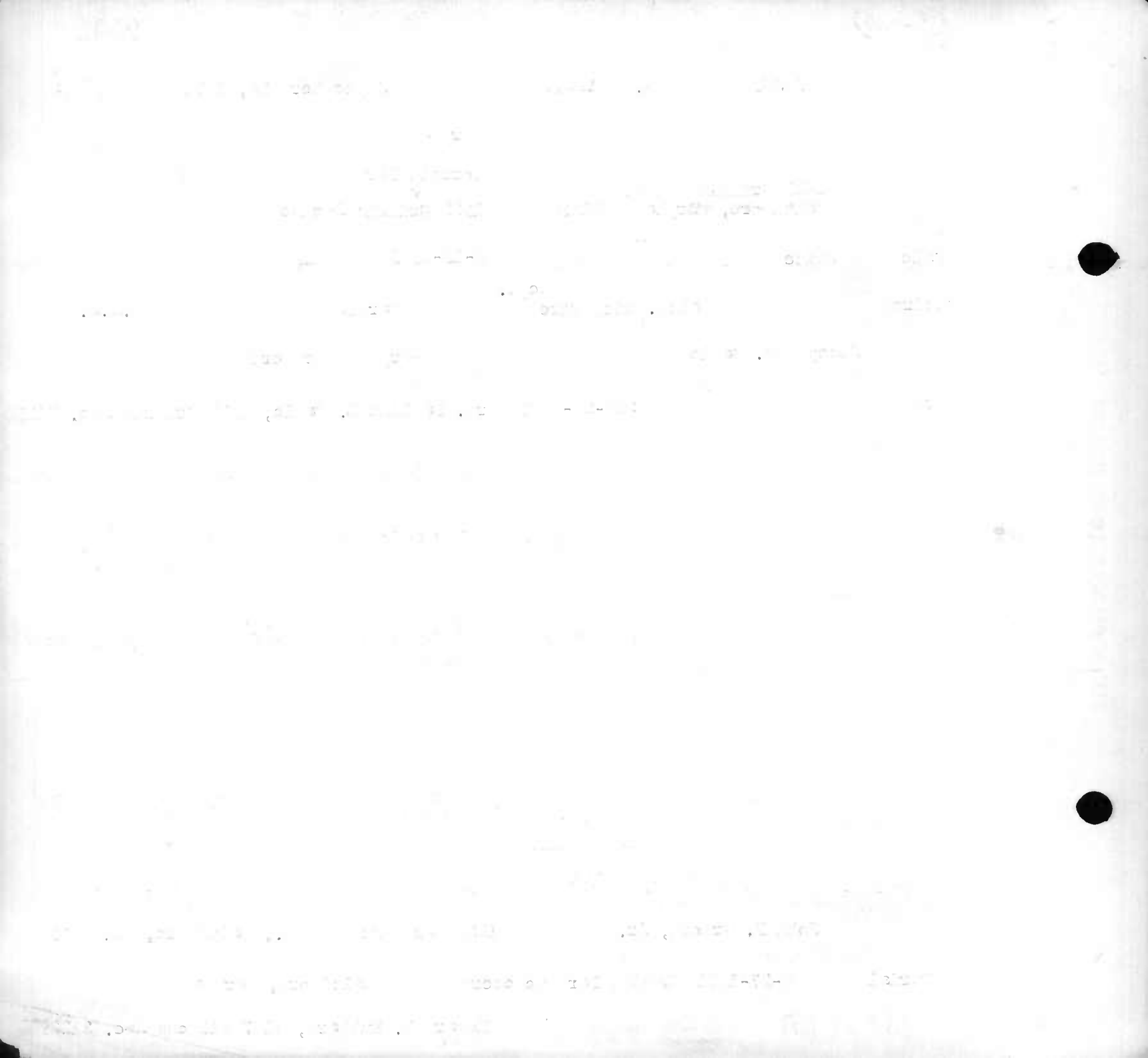


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71</span> <span style="font-size: 1.5em;">9001</span>	
BIRTH NO. <span style="font-size: 1.5em;">G-140</span> <span style="font-size: 1.5em;">71</span> <span style="font-size: 1.5em;">9001</span>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
JOSEPH H. GABLE			September 24, 1971 <span style="float: right;">3.1 M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 1.5em;">00</span> 1922 Griffis Avenue Baltimore, Maryland 21230			A. STATE Maryland		
			B. COUNTY <span style="font-size: 1.5em;">2553</span>		
5. SEX Male			6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 6-15-1905			9. AGE (In years last birthday) 66		If Under 1 Yr. Menhs: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY Dept. Balto. City Fire		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Joseph H. Gable			14. MOTHER'S MAIDEN NAME Mary Wehnert		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 214-20-0807		17. INFORMANT Mrs. Pauline L. Gable, 1922 Griffis Ave. 21230
18. <span style="font-size: 1.5em;">4337</span> I			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Cerebral Thrombosis</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">Sudden</span>
			(B) <span style="font-size: 1.5em;">Cerebral Arteriosclerosis</span> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">7 years</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			<span style="font-size: 1.5em;">Cerebral Thrombosis left</span>		<span style="font-size: 1.5em;">4 years</span>
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">1-19</span> 19 <span style="font-size: 1.5em;">62</span> to <span style="font-size: 1.5em;">9/24</span> 19 <span style="font-size: 1.5em;">71</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">8/24</span> 19 <span style="font-size: 1.5em;">71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">John P. Urlock, Jr.</span>				23B. DATE SIGNED <span style="font-size: 1.5em;">9/24/71</span>	
23C. PHYSICIAN'S NAME (Type) John P. Urlock, Jr.				23D. ADDRESS 1227 Washington Blvd., Baltimore, Md. 21230	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-27-1971		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">SEP 27 1971</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">R. E. Gable, M.D.</span>		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-435 71 9002				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X REG. NO. 71 9002	
1. NAME OF DECEASED (Type or Print) <b>WALTON, WALTER</b>				2. DATE AND HOUR OF DEATH <b>SEPTEMBER 24, 1971 11:35A.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>					
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST. AGNES HOSPITAL</b>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER <b>1063 Elm Road</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>01/03/02</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHIPPING CLERK</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>ELEVATOR CO</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN WALTON</b>				14. MOTHER'S MAIDEN NAME <b>MARY STEVENS WALTON</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>212-07-7567</b>		17. INFORMANT <b>Mrs. Marie A. Walton</b> ADDRESS <b>1063 Elm Road 21227</b>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Approximately 2-4 days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:									
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Cancer at head of pancreas</b>									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>SEPTEMBER 18 1971</b> to <b>SEPTEMBER 24 1971</b> that (I) (we) last saw the deceased alive on <b>SEPTEMBER 24 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>J. Mysombury MD</b>				DEGREE		23B. DATE SIGNED <b>9/24</b>			
23C. PHYSICIAN'S NAME (Type) <b>JESADA MUANGSOMBUT MD</b>		DEGREE		23D. ADDRESS <b>BALTIMORE, MD 21229</b> <b>ST. AGNES HOSPITAL; CATON &amp; WILKENS AVES</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-28-1971</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE RECD. BY HEALTH DEPT. <b>SEP 27 1971</b>		25B. NAME OF REGISTRAR <b>Robert J. ...</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave. 21229</b>			

10:20

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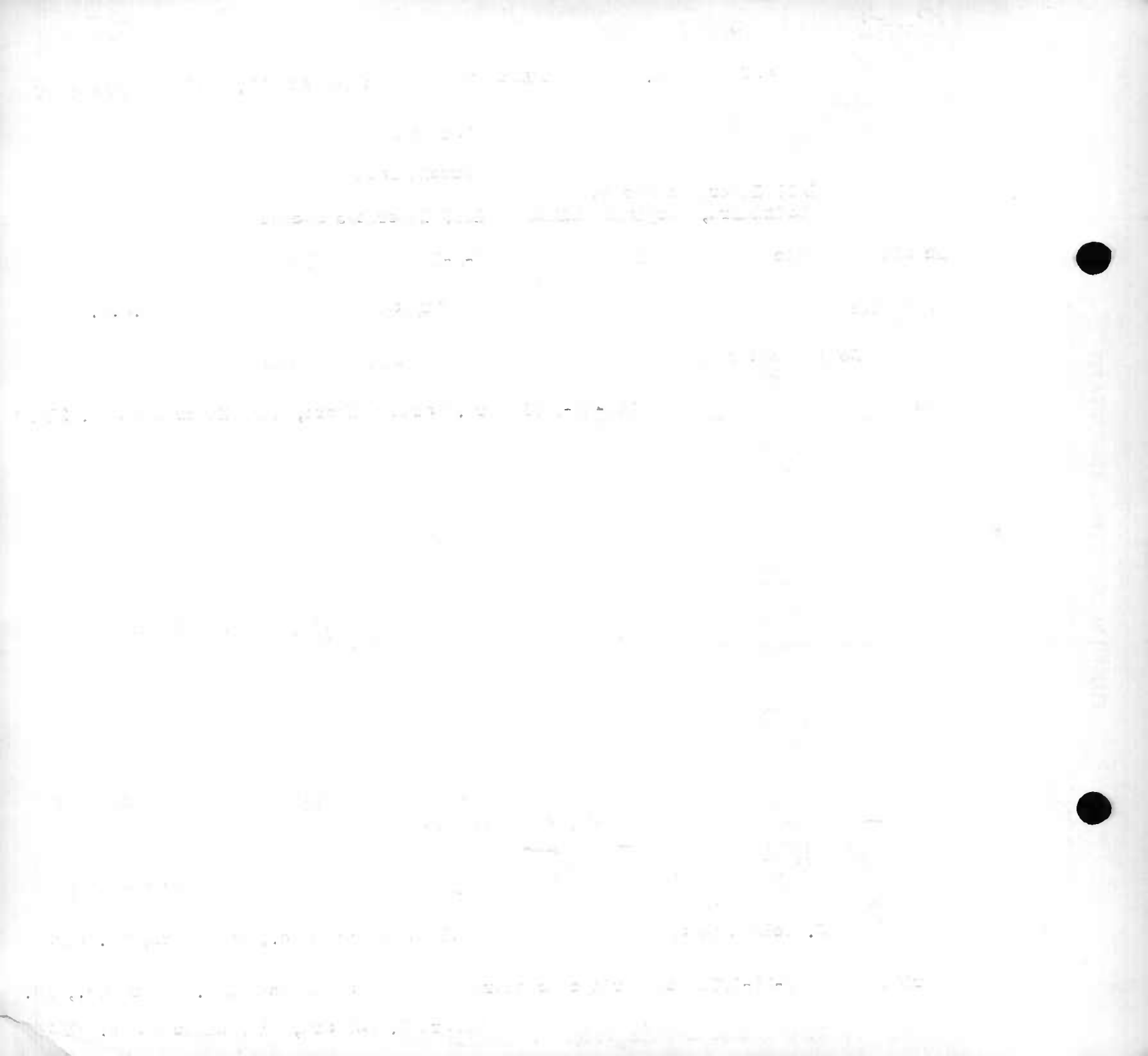
WALTON, WALTER

WALTON, WALTER

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

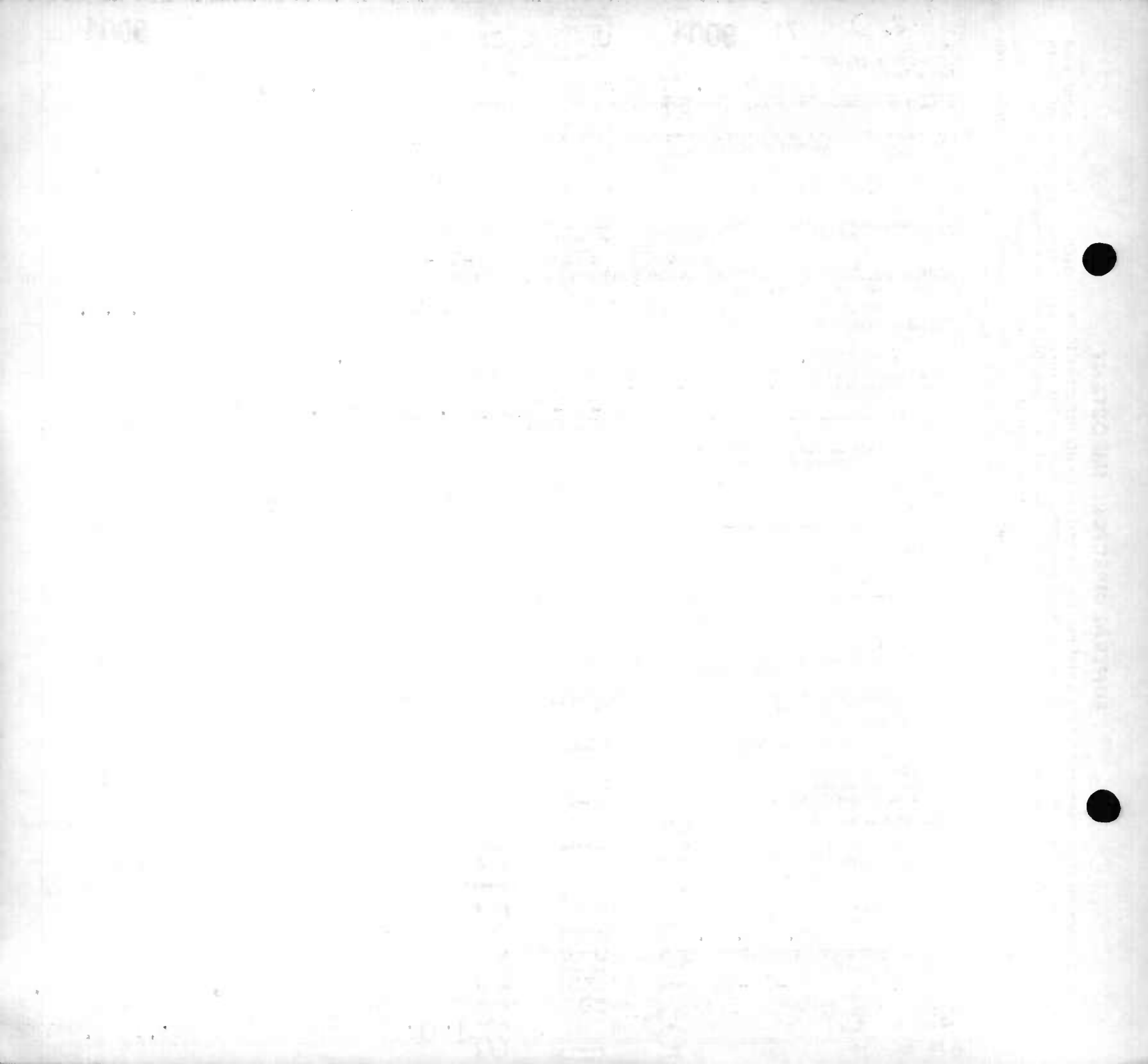
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9003</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">C-152 71 9003</span> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div> </div>					
1. NAME OF DECEASED (Type or Print)		MARY E. CAVANAUGH		2. DATE AND HOUR OF DEATH September 22, 1971 <span style="float: right;">1:00 P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  00 1637 Inverness Avenue Baltimore, Maryland 21230		A. STATE Maryland			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Morrell Park		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1637 Inverness Avenue			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-5-1900	9. AGE (in years last birthday) 71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Cavanaugh		14. MOTHER'S MAIDEN NAME Ann Walsh			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-40-9035		17. INFORMANT Mrs. Marie Walbert, 1637 Inverness Ave., 21230	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Alcohol abuse, cardiac</i>  (B) <i>Angina Pectoris</i> DUE TO, OR AS A CONSEQUENCE OF:  (C)  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Right Hemiparesis (Stroke), Diabetes Mellitus</i>					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, home, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1968</u> to <u>Sept. 22, 1971</u> that (I) (we) last saw the deceased alive on <u>Sept. 17, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J. Nelson McKay</i>				23B. DATE SIGNED 9/24/71	
23C. PHYSICIAN'S NAME (Type) J. Nelson McKay				23D. ADDRESS 6014 Edmondson Ave., Baltimore, Md. 21228	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-27-1971		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	
24D. LOCATION Washington Blvd. Howard Co., Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971			
25B. NAME OF REGISTRAR <i>Howard H. Hubbard</i>		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. <u>71 9004</u>	
7-260 71 9004		CERTIFICATE OF DEATH			
1. NAME OF DECEASED Type or Print		Mary E. Fisher		2. DATE AND HOUR OF DEATH Sept. 24, 1971 6 <sup>00</sup> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland Baltimore		5300	
90 Longgreen Nursing Home		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER		7004 Bellona Avenue	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. UNDER 1 Yr. Months Days
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	7-12-1909	62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Secretary		Medical		Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		James A. Clark		Mary H. Lauer	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		426-18-5143		Mr. Arthur C. Fisher	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 21 Sept 71 to 24 Sept 71 that (I) (we) last saw the deceased alive on 21 Sept 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
[Signature]		24 Sept 71		Dr. Wm. G. Helfrich	
23D. ADDRESS		23E. PHYSICIAN'S DEGREE		23F. PHYSICIAN'S TITLE	
5006 Roland Avenue		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9-27-71		Druid Ridge Cemetery	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)		24F. LOCATION (City, town, or county)	
Pikesville,		Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 27 1971		[Signature]		H. W. Jenkins & Sons Co.	
25D. ADDRESS		25E. ADDRESS		25F. ADDRESS	
4005 York Road Balto., Md. 21212					



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 9005</u>	
H-220 71 9005		BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Lula C. Hughes		Sept. 24, 1971 <span style="float: right;">9:30 A.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  00 3706 Ednor Road				A. STATE Maryland			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3706 Ednor Road							
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-14-1887	
9. AGE (In years last birthday) 83		10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent				10B. KIND OF BUSINESS OR INDUSTRY Emerson Hotel		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Dempsey				14. MOTHER'S MAIDEN NAME Brown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-22-6753		17. INFORMANT Mrs. Joseph Stumpeel 3702 Yolando Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  MASSIVE MYOCARDIAL INFARCTION (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>AUGUST 1970</u> to <u>SEPT 1971</u> and that (2) (we) lost saw the deceased alive on <u>SEPT 4 1971</u> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>W. M. Smith</i>				23B. DATE SIGNED 9/25/71			
23C. PHYSICIAN'S NAME (Type) Dr. Meredith W. Smith				23D. ADDRESS 6305 The Alameda			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-27-71		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1971		25B. NAME OF REGISTRAR R. J. ...		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto., Md. 21212	

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Release by Medical Examiner 9-25-71  
FURNAL DIRECTOR: IMPORTANT  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**DEATH CERTIFICATE**

**REG. NO. 71 9006**

**BIRTH NO. N-350 71 9006**

**1. NAME OF DECEASED (Type or Print)** NEWTON, VERNA C.

**2. DATE AND HOUR OF DEATH** 9-25-71 8:23 A.M.

**3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD**

**4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)**  
A. STATE MARYLAND B. COUNTY BALTIMORE

**5. SEX** FEMALE

**6. RACE** WHITE

**7. MARRIED** ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

**8. DATE OF BIRTH** 5-14-83

**9. AGE (in years last birthday)** 88

**10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)** HOMEMAKER

**11. BIRTHPLACE (State or foreign country)** BALTIMORE, Md.

**12. CITIZEN OF WHAT COUNTRY** U.S.A.

**13. FATHER'S NAME** HARRY CLARK

**14. MOTHER'S MAIDEN NAME** MARY DUFFY

**15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)** NO

**16. SOCIAL SECURITY NO.** 220-44-0973

**17. INFORMANT** MRS. L. E. BIE MILLER

**18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  
II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  
FRACTURED RIGHT HIP.

**19A. DATE OF OPERATION** 9-15-71

**19B. CONDITION FOR WHICH OPERATION WAS PERFORMED** FX. RIGHT HIP

**20A. AUTOPSY? (Yes or No)** NO

**20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?**

**21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)** ☐

**21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)** RESWICK NURSING HOME

**21C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location) 1307 700 W 40TH STREET BALT, 11, MD.

**21D. TIME OF INJURY (APPROX.)** 9-13-71

**21E. INJURY OCCURRED** While At Work ☐ Not While At Work ☒

**21F. HOW DID INJURY OCCUR?** FELL WHILE WALKING

**22. I certify that (I) (this hospital) attended the deceased from 9/13/71 to 9/25/71 that (I) (we) last saw the deceased alive on 9/24/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.**

**23A. SIGNATURE** Dr. Kirby L. C. von Kessler

**23B. DATE SIGNED** 9/25

**23C. PHYSICIAN'S NAME (Type)** Dr. Kirby L. C. von Kessler

**23D. ADDRESS** 4 E. Madison St.

**24A. BURIAL, CREMATION, REMOVAL (Specify)** Burial

**24B. DATE** 9-28-71

**24C. NAME OF CEMETERY OR CREMATORY** Loudon Park Cemetery

**24D. LOCATION (City, town, or county) (State)** Balto., Md.

**25A. DATE REC'D BY HEALTH DEPT.** SEP 27 1971

**25B. NAME OF REGISTRAR** H. W. Jenkins & Sons Co.

**25C. FUNERAL DIRECTOR ADDRESS** 41905 York Road Balto., Md. 21212

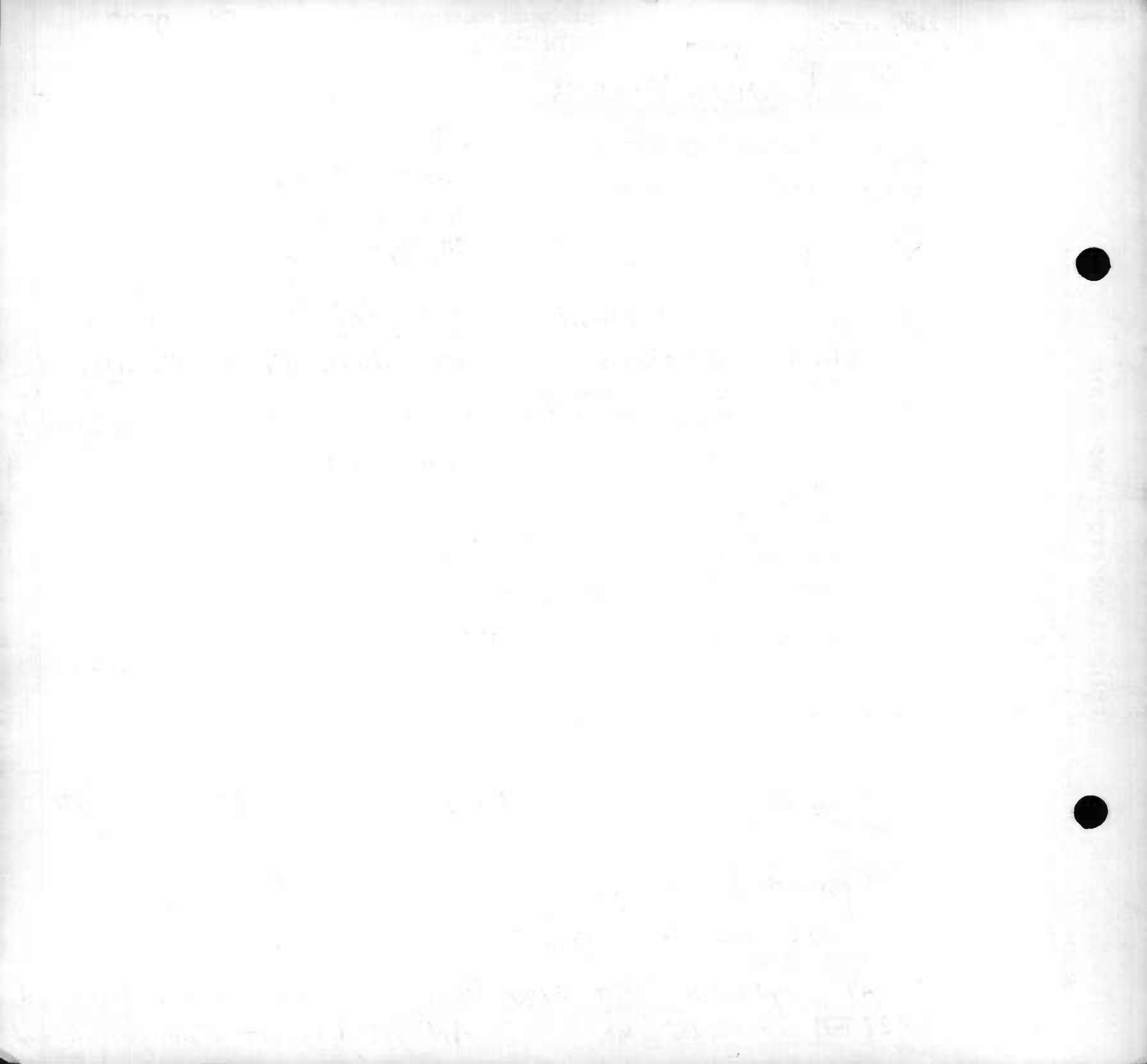
Adm 4/9/69

205 Wither spoon Rd.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

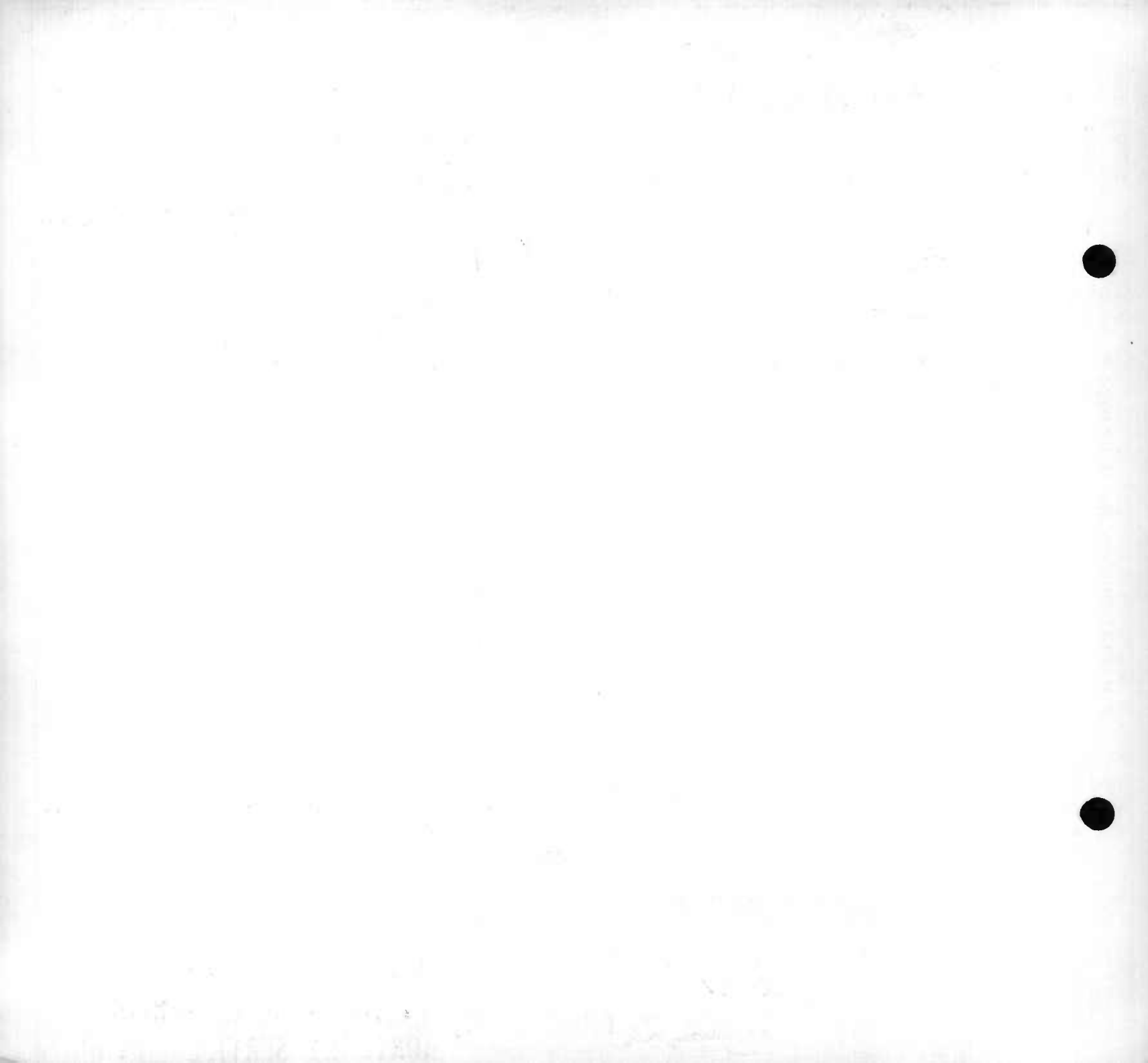
BALTIMORE CITY HEALTH DEPARTMENT				X		71 9007	
M-252 71 9007				CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>ROLAND E. MEEKINS</b>				2. DATE AND HOUR OF DEATH <b>9/23/71 10:10 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>12 SINAI HOSP. OF BALTO.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>BALTO. MARYLAND</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>Kennar Ave.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/12/95</b>		9. AGE (in years last birthday) <b>76</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Linesman</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>BALTO TRANSIT CO.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Joshua Meekins</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Ramon Cornthwaite</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW.I</b>			16. SOCIAL SECURITY NO. <b>216-09-8066</b>		17. INFORMANT ADDRESS <b>Roland K. Meekins Sr. St. Thomas Lane Owings Mills Md.</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>MI, acute</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b> <b>CHF</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (he) (this hospital) attended the deceased from <b>9/21/71</b> 19 to <b>9/23</b> 1971 that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Fortunato V. Elizaga M.D.</b>				23B. DATE SIGNED <b>9/23/71</b>		23C. PHYSICIAN'S NAME (Type) <b>FORTUNATO V. ELIZAGA MD</b>	
23D. ADDRESS <b>SINAI HOSP.</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>Sept 27, 1971</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Randallstown Balto. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 27 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. J. Baker, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>110905 Edmond Owings Mills Md.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

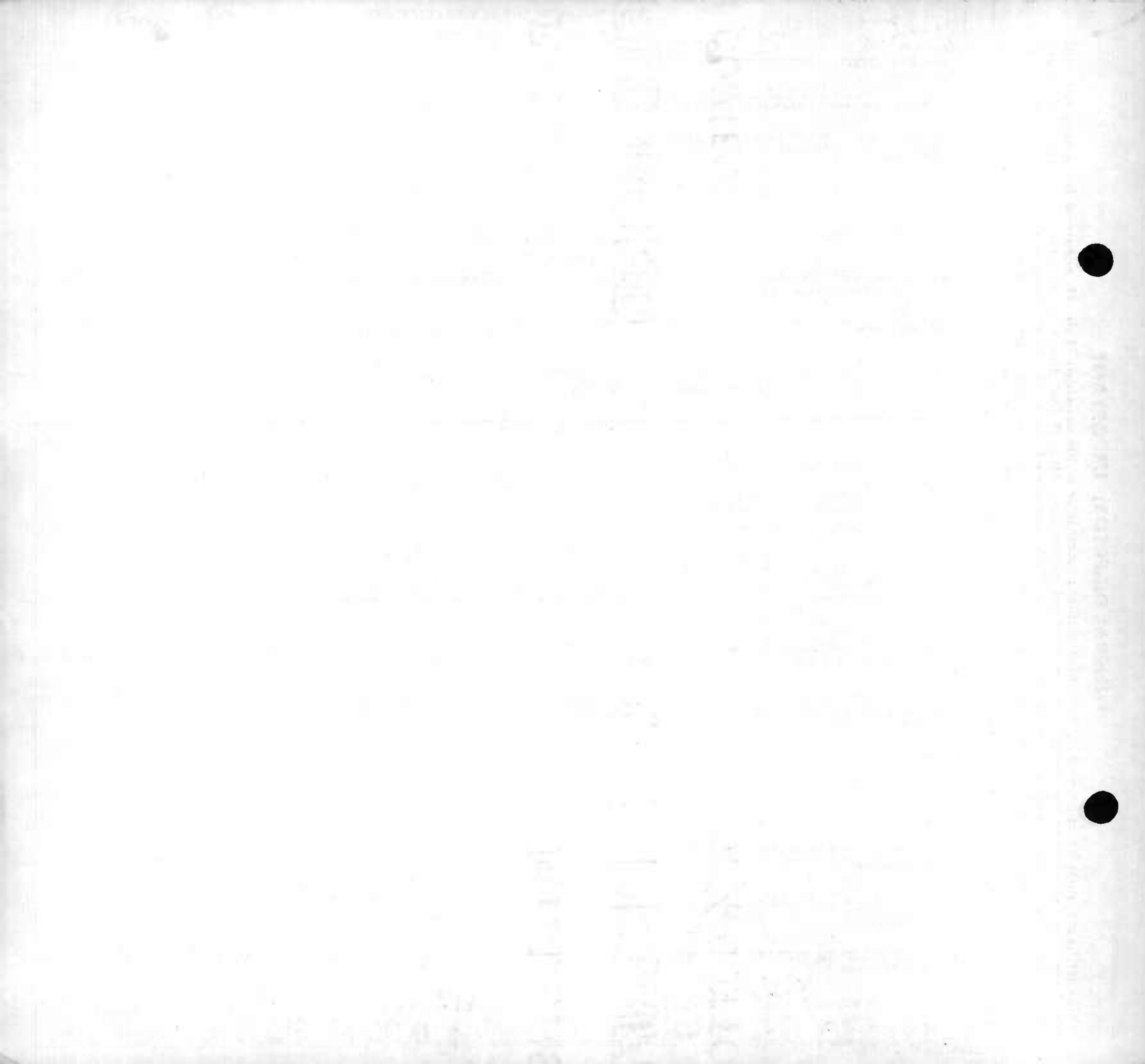
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9008</u>
C-600				4
BIRTH NO. <u>71-1573471</u> <u>9008</u>				CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <u>Baby Girl Curry</u>		2. DATE AND HOUR OF DEATH <u>9/14/71</u> <u>9:00 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Md. Hospital</u> <u>35</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3421 Calton Ave</u> <u>NEIGHBORHOOD</u> <u>Back 21229 Rd</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/12/71</u>	9. AGE (In years last birthday) <u>2</u> <u>3</u> Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Howard Tucker</u>		
14. MOTHER'S MAIDEN NAME <u>Curry Karen</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Hemorrhage</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>45 min</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Severe Hyaline Membrane Disease 2 days</u>		
		(B) <u>Prematurity - 33-34 wks gestation</u> <u>2 days</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Prematurity</u>				
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?				
22. I certify that (1) (this hospital) attended the deceased from <u>9/12</u> 19 <u>71</u> to <u>9/14</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>9/14</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Margan J. Chang M.D.</u>		23B. DATE SIGNED <u>9/14</u>		23C. PHYSICIAN'S NAME (Type) <u>MARGAN J. CHANG M.D.</u>
23D. ADDRESS <u>University Hospital</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>9-23-71</u>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <u>ANATOMY BOARD OF MARYLAND</u>
24D. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1971</u>		24E. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		24F. SIGNATURE OF REGISTRAR <u>UNIVERSITY MEDICAL SCHOOL</u>
24G. MORTUARY SERVICE - BCHD				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9009</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">M-216</span>		<b>CERTIFICATE OF DEATH</b>			
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">McFarland, Spurgeon</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">Sep. 19, 1971   2:30 P.M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">Mercy Hospital, Baltimore</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">401</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">514 E. Pratt St.</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">white</span>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">11-01-15</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">55</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired</span>			<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">N. Carolina</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">American</span>
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Charles McFarland</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Bossie Graham</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT ADDRESS</b>	
<b>18. CAUSE OF DEATH</b>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>(A) IMMEDIATE CAUSE</b> <span style="font-size: 1.2em;">Anoxia, pneumonia, sepsis</span> <b>DUE TO, OR AS A CONSEQUENCE OF:</b>  <b>(B)</b> <span style="font-size: 1.2em;">Aspiration, debilitation</span> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C)</b> <span style="font-size: 1.2em;">CVA - MI</span>	
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">2</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">Yes</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">9/3</span> <b>19</b> <span style="font-size: 1.2em;">71</span> <b>to</b> <span style="font-size: 1.2em;">9/19</span> <b>19</b> <span style="font-size: 1.2em;">71</span> <b>that (I) (we) lost</b> <span style="font-size: 1.2em;">saw</span> <b>the deceased alive on</b> <span style="font-size: 1.2em;">9/14</span> <b>19</b> <span style="font-size: 1.2em;">71</span> <b>and that in (my) (our)</b> <span style="font-size: 1.2em;">our</span> <b>opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">John Ohe MD</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">9/19/71</span>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <span style="font-size: 1.2em;">John Ohe MD</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">Mercy Hospital, Baltimore</span>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b>		<b>24B. DATE</b> <span style="font-size: 1.2em;">9-24-71</span>		<b>24C. NAME OF CEMETERY or CREMATOR</b> <span style="font-size: 1.2em;">ANATOMY BOARD OF MARYLAND</span>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b>		<b>25B. NAME OF REGISTRAR</b>		<b>25C. FUNERAL DIRECTOR'S ADDRESS</b>	
<b>UNIVERSITY MEDICAL SCHOOL</b> <b>MORTUARY SERVICE - BCHD</b>					





# FUNERAL DIRECTOR: IMPORTANT

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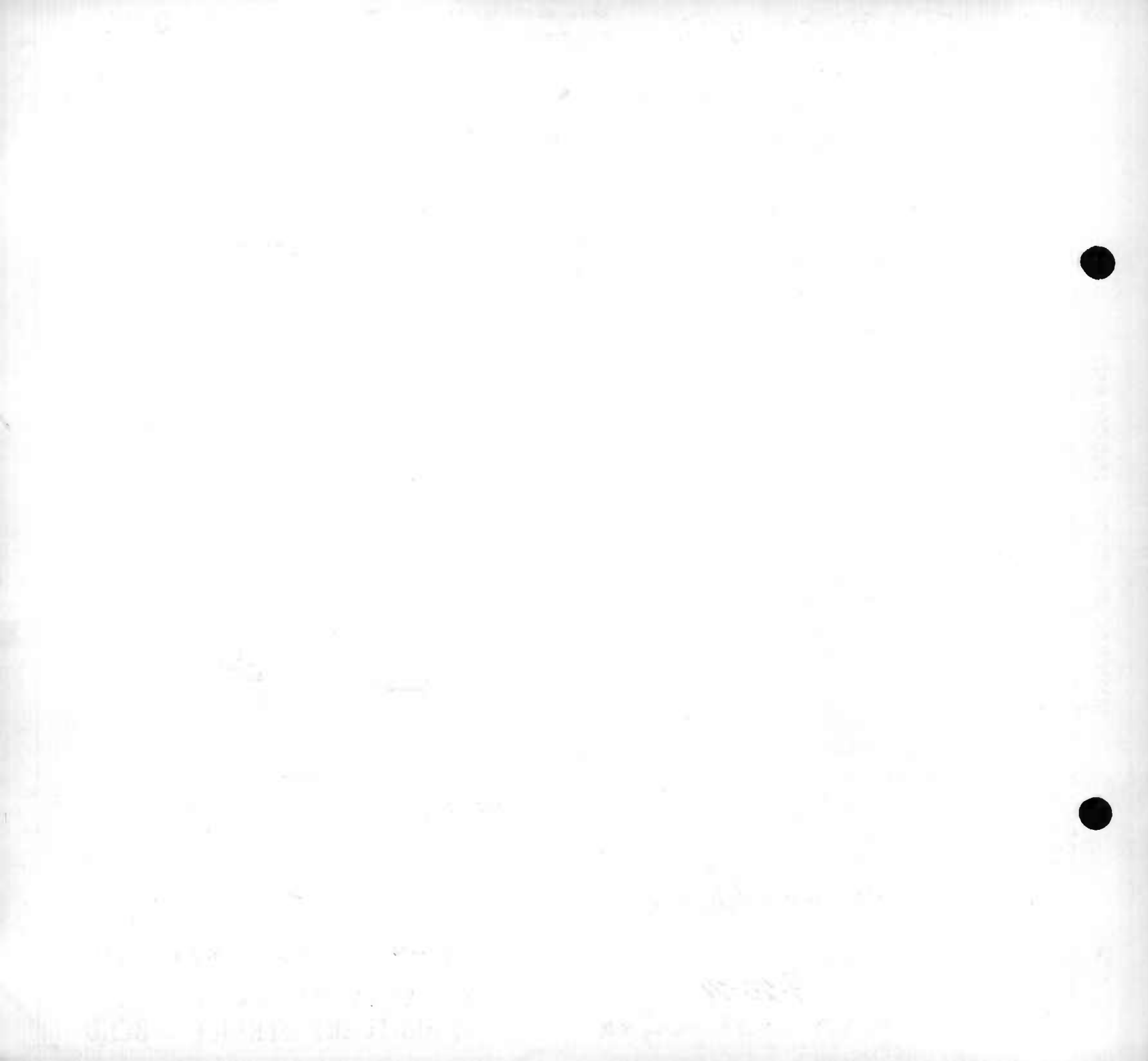
Baltimore City Health Department CERTIFICATE OF DEATH				REG. NO. <u>71 9010</u>
BIRTH NO. <u>7622</u>		1. NAME OF DECEASED (Type or Print) <u>ROSA FERGUSON</u>		2. DATE AND HOUR OF DEATH <u>9/19/71</u> <u>4:40 P.M.</u>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BON SECOURS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1604</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>727 MONROE ST.</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>BLACK</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/03/05</u>	9. AGE (In years last birthday) <u>65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>225-28-0204</u>		
16. SOCIAL SECURITY NO. <u>PT. CHART</u>		17. INFORMANT ADDRESS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> <u>years</u>
19A. DATE OF OPERATION <u>09/16</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>09/19 4:40 PM</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>09/16</u> 19 <u>71</u> to <u>09/19</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>09/19 4:40 PM</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>M. D.</u>		23B. DATE SIGNED <u>9/19/71</u>		23C. PHYSICIAN'S NAME (Type) <u>TAE S. AHN M.D.</u>
23D. ADDRESS <u>BON SECOURS HOSP. BALT. MD.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>9-23-71</u>		
24B. DATE <u>9-23-71</u>		24C. NAME OF CEMETERY OR CREMATOR <u>ANATOMY BOARD OF MARYLAND</u>		
24D. LOCATION <u>UNIVERSITY MEDICAL SCHOOL</u>		24E. NAME OF REGISTRAR <u>MORTUARY SERVICE - BCHD</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

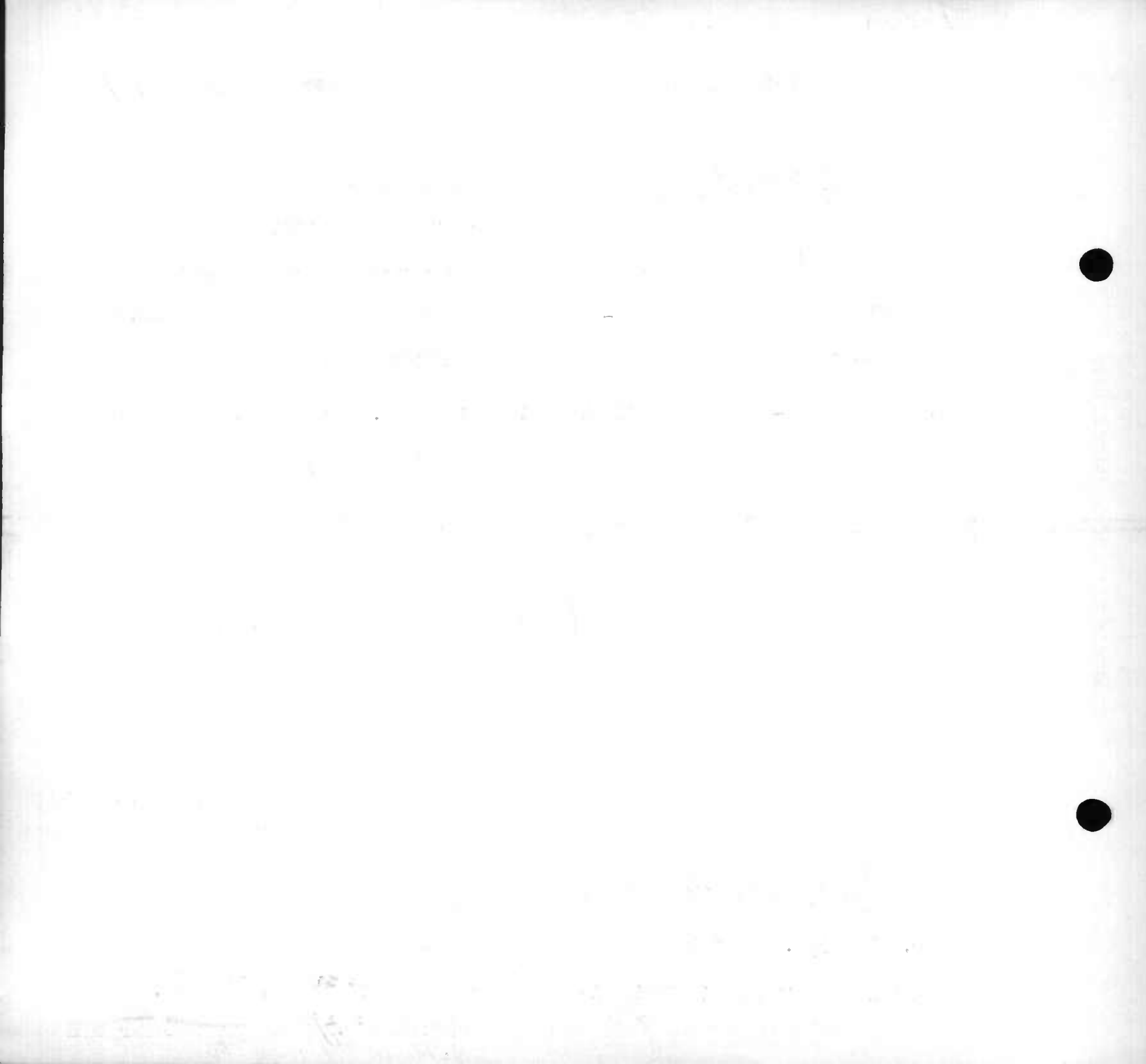
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9311</u>
T-460 71 9311		CERTIFICATE OF DEATH		
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Taylor, Jessie</u>		September 17, 1971 9:45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>1024 W. Baltimore St</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-35</u>	9. AGE in years last birthday <u>36</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
				12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>4829 15-2504</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Endotoxic Shock</u> (B) <u>? Proteus Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Gastric Ulcer, Diabetes</u>		
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		<input checked="" type="checkbox"/>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 17</u> 19 <u>71</u> to <u>Sept 17</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Sept 17</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Aurea Hill</u>		23B. DATE SIGNED <u>9/17/71</u>		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <u>9-23-71</u>	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1971</u>	25B. NAME OF REGISTRAR <u>John E. Taylor, M.D.</u>	25C. FUNERAL HOME OR MORTUARY SERVICE - <u>BCHD</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

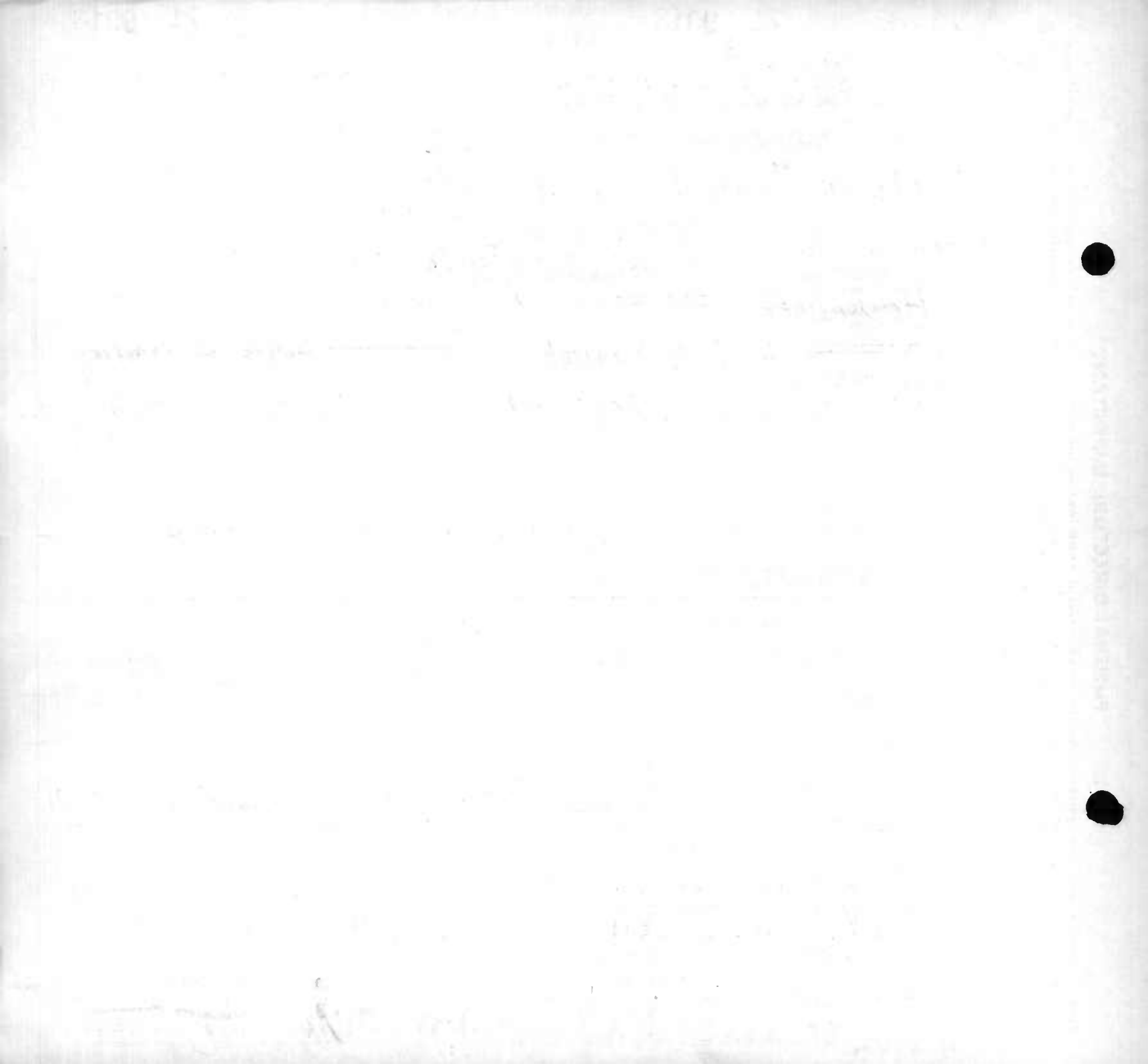
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9012</u>
BIRTH NO. <u>R-200</u>		71 9012		
1. NAME OF DECEASED (Type or Print) <u>MARGARET OLGA ROCHE</u>		2. DATE AND HOUR OF DEATH <u>September 24, 1971</u> <u>11</u> <u>AM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Longreen Nursing Home</u> <u>115 East Melrose Avenue</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
		C. CITY OR TOWN <u>Cockeysville</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER <u>5 Hickory Hill Road</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5 1896</u>	9. AGE (In years last birthday) <u>75</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Hook</u>		
14. MOTHER'S MAIDEN NAME <u>Margaret Stanton</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>212 10 0627</u>		17. INFORMANT <u>William R. Roche 5 Hickory Hill Road</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerosis</u> <u>Diabetes</u> <u>Cancer of bladder</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>1960</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>Sept 24 1971</u> that (I) (we) last saw the deceased alive on <u>Sept 21 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Dr. William G. Helfrich</u>		23B. DATE SIGNED <u>9/27/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. William G. Helfrich</u>
23D. ADDRESS <u>5006 Roland Avenue</u>		24. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>27 Sept 71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Bal to Co. Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, R.D.</u>		25C. FUNERAL DIRECTOR <u>Burge Funeral Home Baltimore Maryland</u>
25D. ADDRESS <u>By: Norman H. Sarge Jr</u>				



# FUNERAL DIRECTOR: IMPORTANT

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B-620 71 9013				BALTIMORE CITY HEALTH DEPARTMENT		71 9013	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>JESSIE BRISCOE</b>				2. DATE AND HOUR OF DEATH <b>September 25 12.45 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>441 Union Memorial Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <b>MARYLAND</b>		B. COUNTY <b>1306</b>	
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3644 ELM AVE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 16 1887</b>		9. AGE (in years lost birthday) <b>84</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob N Shauck</b>				14. MOTHER'S MAIDEN NAME <b>Susie E Radley</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>165050001</b>		17. INFORMANT ADDRESS <b>LOUISA MKROUT 3646 Hickory Ave</b>			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>DEHYDRATION</b>							
19A. DATE OF OPERATION <b>9-25-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>September 24 1971</b> to <b>September 25 1971</b> that (I) (we) last saw the deceased alive on <b>September 25 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Mirve Karacusciansky M.D.</b>						23B. DATE SIGNED <b>9-25-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Mirve KARACUSCIANSKY M.D.</b>		23D. ADDRESS <b>Union Memorial Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>28 Sep 71</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Mary's Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Roland Avenue, Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Larges Funeral Home Baltimore Maryland</b>			

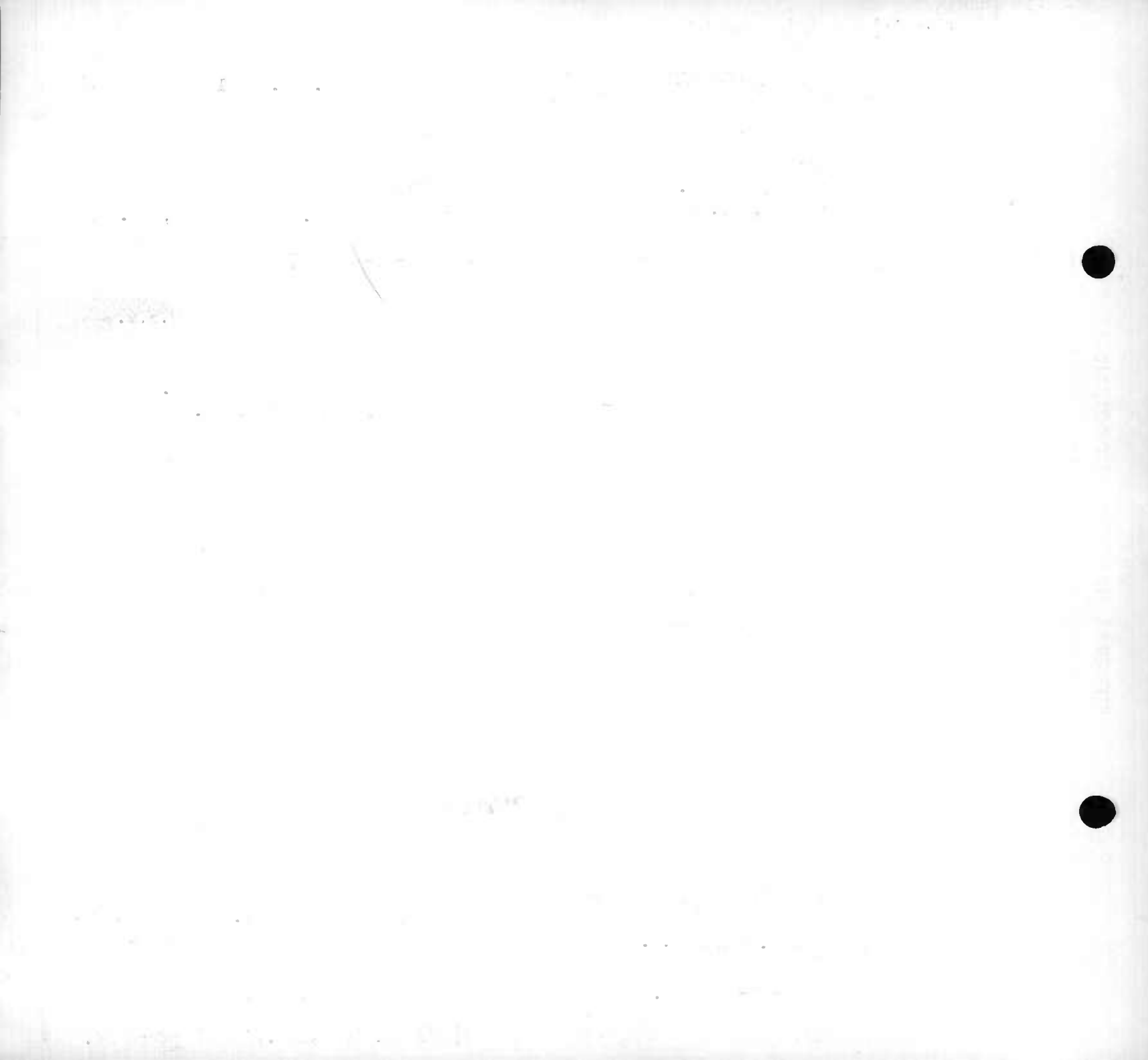




# FUNERAL DIRECTOR: IMPORTANT

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58-60-18		BALTIMORE CITY HEALTH DEPARTMENT		71 9014	
B-200		71 9014		REG. NO. 71 9014	
BIRTH NO.		71 9014		71 9014	
1. NAME OF DECEASED (Type or Print) <u>Ida Hedwig (Jadwiga) Beck-Bekinski</u>		2. DATE AND HOUR OF DEATH <u>Sept. 26. 1971</u> <u>12:15 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore /City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Md. 21224</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2611</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3214 Hudson St.</u> <u>Baltimore, Md. 21224</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-17-84</u>	9. AGE (In years lost birthday) <u>86</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Anthony Warczynski</u>		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-44-5509</u>		17. INFORMANT <u>BCH Records: Baltimore, Md. 21224</u> ADDRESS <u>4940 Eastern Ave.</u>	
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Left CVA</u>		(A) IMMEDIATE CAUSE <u>acute ischemic cardiac catastrophe</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) <u>generalized arteriosclerosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 to 10 hours</u> <u>50 years</u> <u>50 years</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>Mar 9</u> 19 <u>71</u> to <u>Sept 26</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>Sept 26</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John W. Kirk M.D.</u>		23B. DATE SIGNED <u>Sept 26, 1971</u>		23C. PHYSICIAN'S NAME (Type) <u>John W. Kirk M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-29-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Miller, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc., 5305 Harford Rd.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 9015</b>	
7-660 71 9015		<b>CERTIFICATE OF DEATH</b>			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>VINCENZO VINCENT FERRARO</b>		2. DATE AND HOUR OF DEATH <b>9 26 71 12 30AM</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2733</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>2/5/97</b>		9. AGE (In years lost birth) <b>74</b>		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Machinist</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BETH STEEL</b>		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>		13. FATHER'S NAME <b>LOUIS FERRARO</b>		14. MOTHER'S MAIDEN NAME <b>MARY BARBERI</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN Yes WW 1</b>		16. SOCIAL SECURITY NO. <b>213-09-1162</b>		17. INFORMANT <b>DR. SHAKER</b> ADDRESS <b>UNION MEMORIAL HOSP.</b>	
18. <b>410.9 I</b> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial infarction</b>			
ANTECEDENT CAUSES		(B) <b>Coronary atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<b>Left hemiparesis</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/26</b> <b>19 71</b> to <b>19</b> that <b>we</b> last saw the deceased alive on <b>5/6</b> <b>19 71</b> and that in (my) <b>apinian</b> death occurred on the date <b>pronounced dead 12 30 Am</b> and hour and from the causes stated above. (I) (We) (did) <b>did not</b> view the body after death.					
23A. SIGNATURE <b>D. J. Shaker, M.D.</b>		23B. DATE SIGNED <b>9/26/71</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>L. J. Shaker MD</b>		23D. ADDRESS <b>Union Memorial Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Entombment</b>		24B. DATE <b>9-30-71</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorraine Maus.</b>	
24D. LOCATION (City, town, or county) <b>Balto. Md.</b>		24E. STATE (State) <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1971</b>		25B. NAME OF REGISTRAR <b>Rebecca Baker</b>		25C. FUNERAL DIRECTOR <b>Leahard &amp; Co. Inc.</b> ADDRESS <b>Balto. Md. 21214</b>	

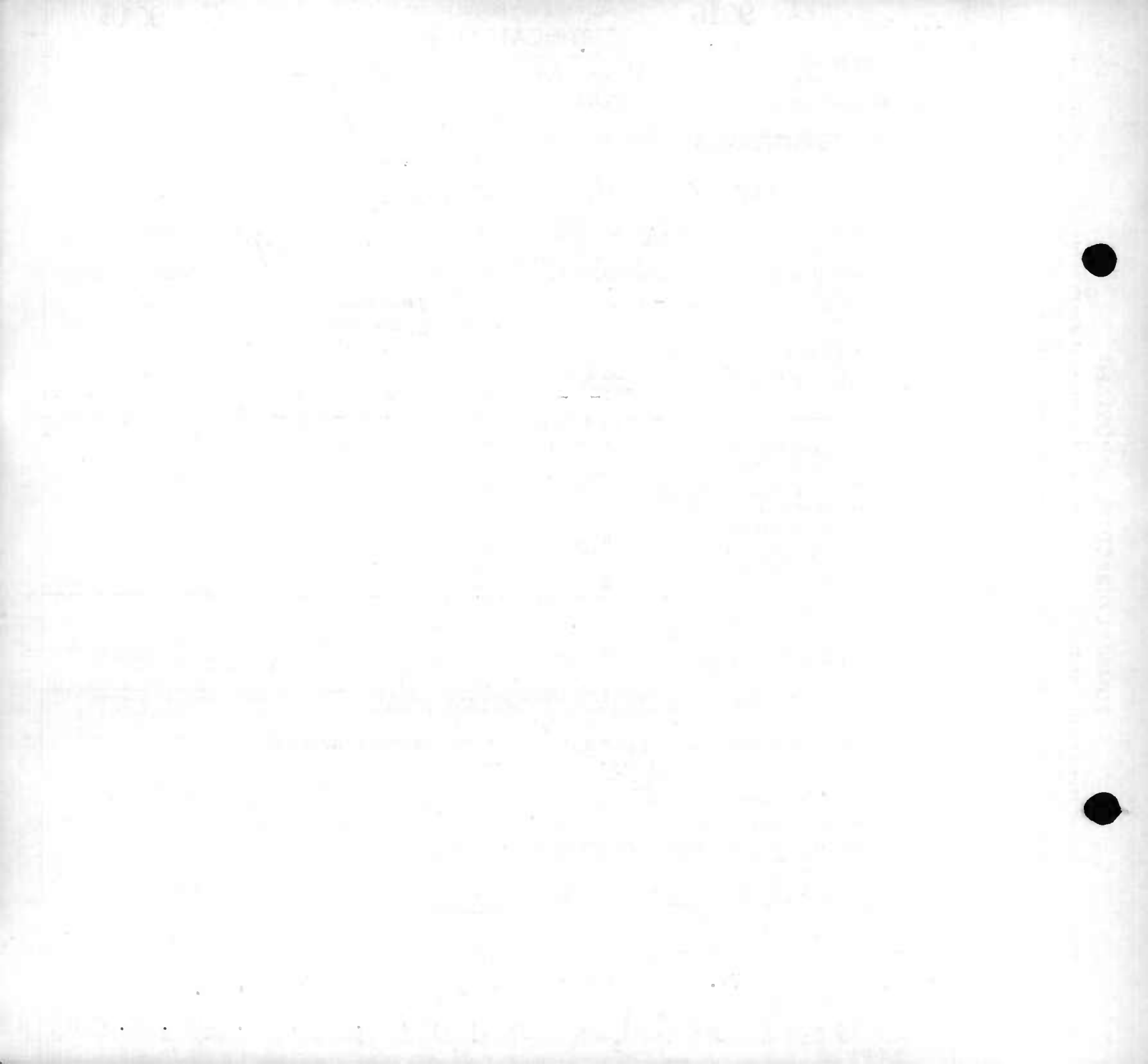
2600 Arthur Ave

2600 Arthur Ave

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 9016	
7-652 9016				CERTIFICATE OF DEATH	
BIRTH NO. FRANKOS; NICHOLAS D.				REG. NO. 71 9016	
1. NAME OF DECEASED (Type or Print)		Frankos, Nicholas D.		2. DATE AND HOUR OF DEATH 26 Sept. 71 10:30 AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md B. COUNTY Balto		2706	
FULL NAME OF HOSPITAL OR INSTITUTION 4 + Union Memorial Hosp.		5. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER Echodale Ave 2812			
5. SEX M.	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-25-03	9. AGE (in years last birthday) 67	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10B. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Greece	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Demetrius Frankos		14. MOTHER'S MAIDEN NAME Penelope Duskas	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 221-05-416		17. INFORMANT Katherine Frankos	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) recurrent Myocardial infarction		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD, CHF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Chronic obstructive lung disease		18 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) CHRONIC obstructive lung disease		yrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1953 to Sept 26 1971 that (I) (we) last saw the deceased alive on Sept. 25 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert W. Garis, M.D.				23B. DATE SIGNED Sept 26, 1971	
23C. PHYSICIAN'S NAME (Type) ROBERT W. GARIS, M.D.				23D. ADDRESS 12 E. EAGER ST., BALTIMORE, MD. 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/29/71		24C. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cemetery	
24D. LOCATION Baltimore, Md.		24E. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		24F. ADDRESS	
25A. DATE RECEIVED BY HEALTH DEPT. SEP 28 1971		25B. NAME OF REGISTRAR SEP 28 1971		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

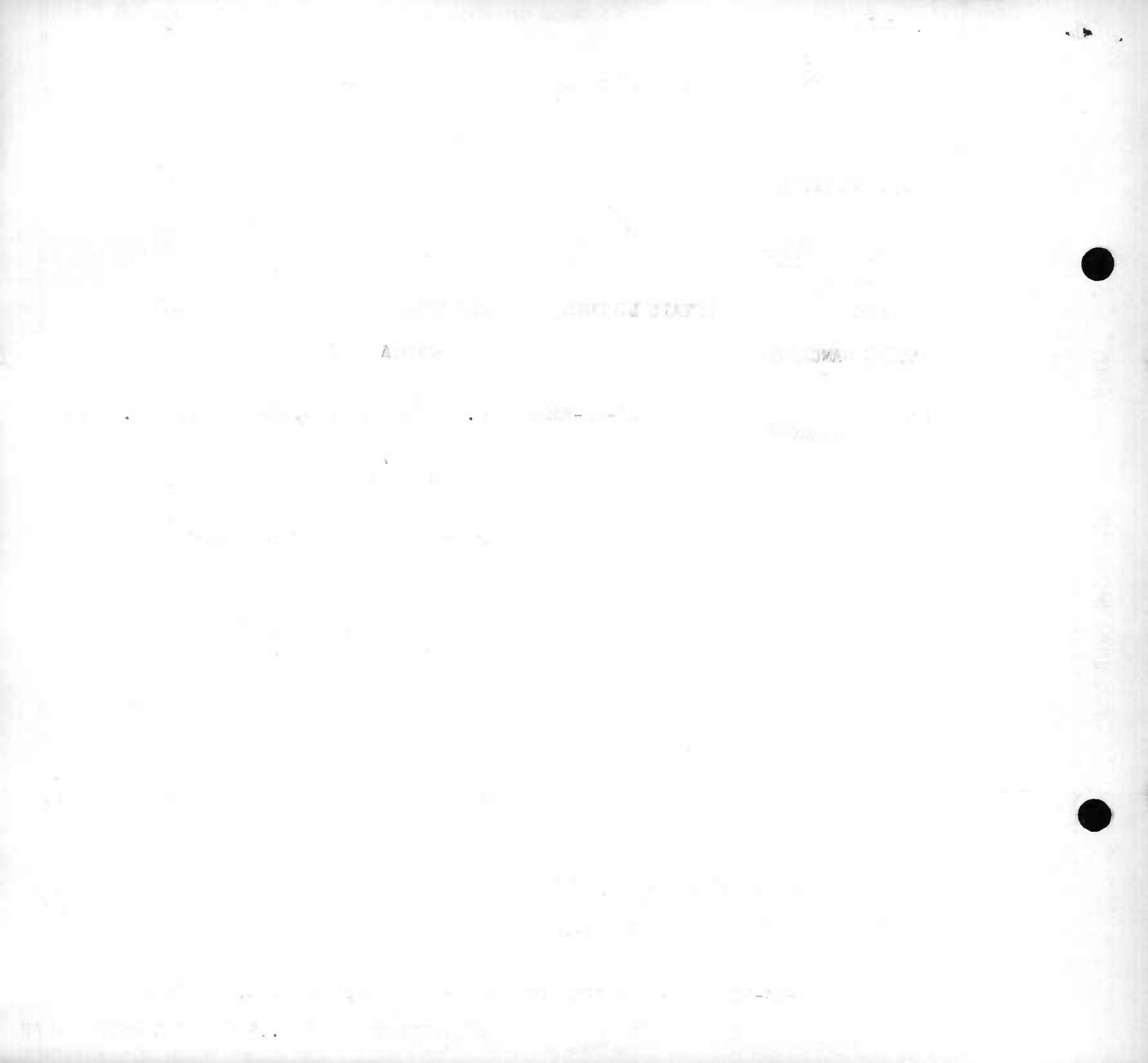
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9017</u>	
BIRTH NO. <u>71 9017</u>		1. NAME OF DECEASED (Type or Print) <u>CLARENCE S. KELLER</u>			
2. DATE AND HOUR OF DEATH <u>9/25/71</u> <u>12:14 A.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		A. STATE <u>MARYLAND</u>		B. COUNTY <u>2745</u>	
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3217 NORTHERN PARKWAY</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>02-28-04</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Manager</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
13. FATHER'S NAME <u>DANIEL W. KELLER</u>		14. MOTHER'S MAIDEN NAME <u>KATIE SNADER</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WW 11</u>		16. SOCIAL SECURITY NO. <u>72-05-3121</u>		17. INFORMANT <u>Mrs Gladys A Hawk</u> ADDRESS <u>Same</u>	
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cordone + Rapidly Arter</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Metastatic Squamous Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Carcinoma of Lung</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<u>Bleeding - Upper GI</u>			
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Trans admission</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/23</u> 19 <u>71</u> to <u>9/25</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/25</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Gregory B. Burkley</u>		23B. DATE SIGNED <u>9/25/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Gregory B. Burkley</u> DEGREE <u>—</u>	
23D. ADDRESS <u>Johns Hopkins Hospital</u>		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		23F. DEGREE <u>—</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/28/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>William Lind Mem</u>	
24D. LOCATION (City, town, or county) (State) <u>Lewistown Penna.</u>		24E. DATE OF REGISTRATION <u>SEP 28 1971</u>		24F. NAME OF REGISTRAR <u>—</u>	
25A. DATE OF REGISTRATION <u>SEP 28 1971</u>		25B. NAME OF REGISTRAR <u>—</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Jack Inc. Baltimore, Md</u>	





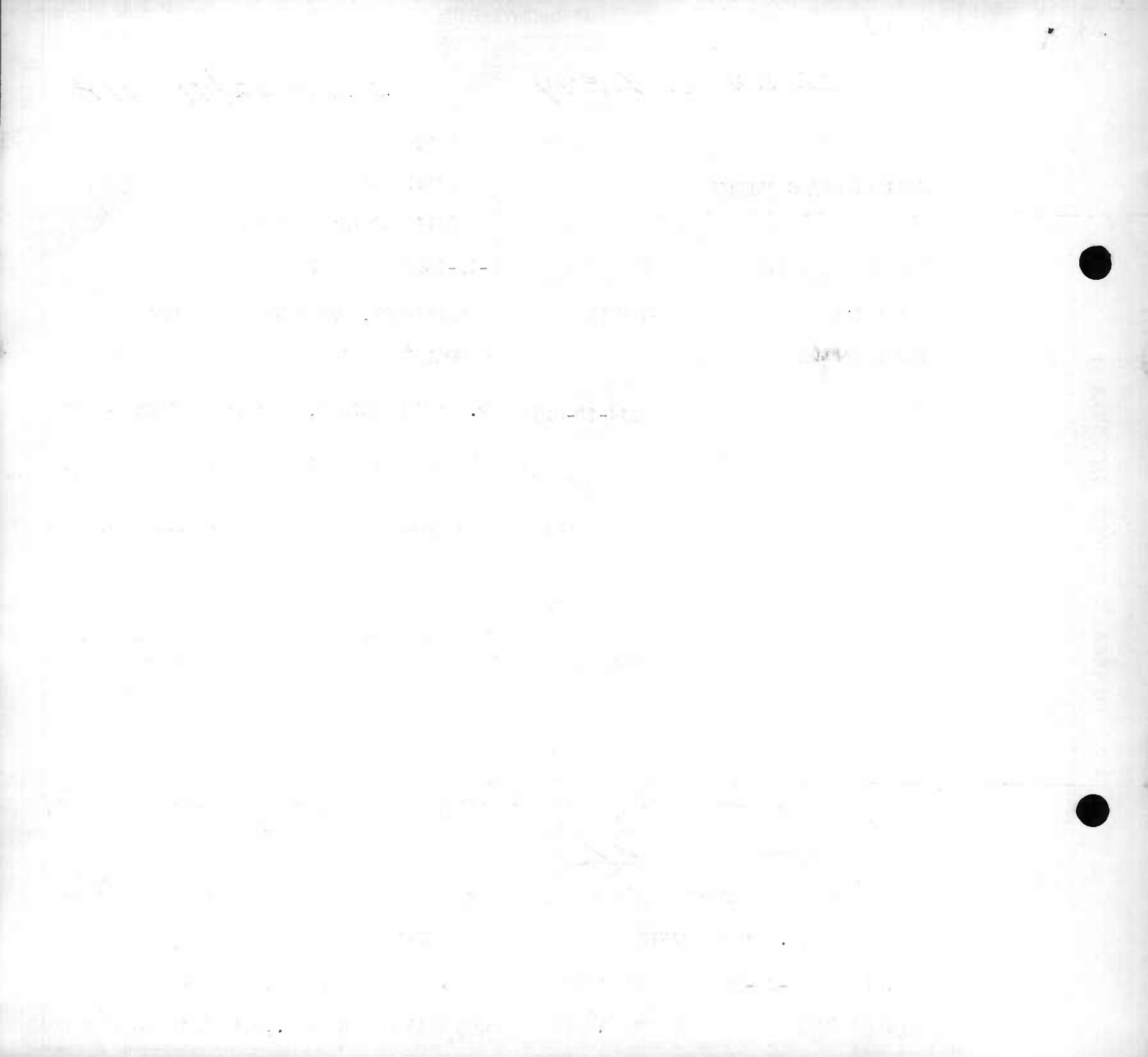
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9018</u>	
BIRTH NO. <u>S-531</u>		71 9018			
1. NAME OF DECEASED (Type or Print) <u>A. SANDBANK, HARRY</u>			2. DATE AND HOUR OF DEATH <u>September 23 - 1971 12:03 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2719</u>		
			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>5521 Rubin Ave #15</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 10/03/06</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL LIQUORS</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>	
13. FATHER'S NAME <u>ELIAS SANDBANK</u>			14. MOTHER'S MAIDEN NAME <u>SOPHIA ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>051-09-8596</u>		17. INFORMANT <u>MRS. CELIA SANDBANK, 5521 RUBIN AVE. #21215</u>	
18. <u>402X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CVA E. Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>CHF chr. renal failure</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) <u>Hypertension</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<u>Diverticulosis; renal cyst.</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-18-1971</u> to <u>9-23-1971</u> that (I) (we) last saw the deceased alive on <u>9-23-1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C. Thanandapanar M.D.</u>				23B. DATE SIGNED <u>9-23-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHALAMPARL THANANDAPARN M.D.</u>				23D. ADDRESS <u>SINAI HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-24-71</u>		24C. NAME of CEMETERY or CREMATORY <u>OHR KNESSETH ISRAEL ANSHE SFARD, ROSEDALE, MARYLAND</u>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1971</u>			
25B. NAME OF REGISTRAR <u>SOL LEVINSON</u>		25C. FUNERAL DIRECTOR <u>BROS., 6010 REISTERSTOWN ROAD</u>			

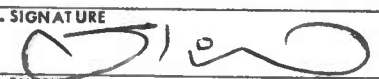


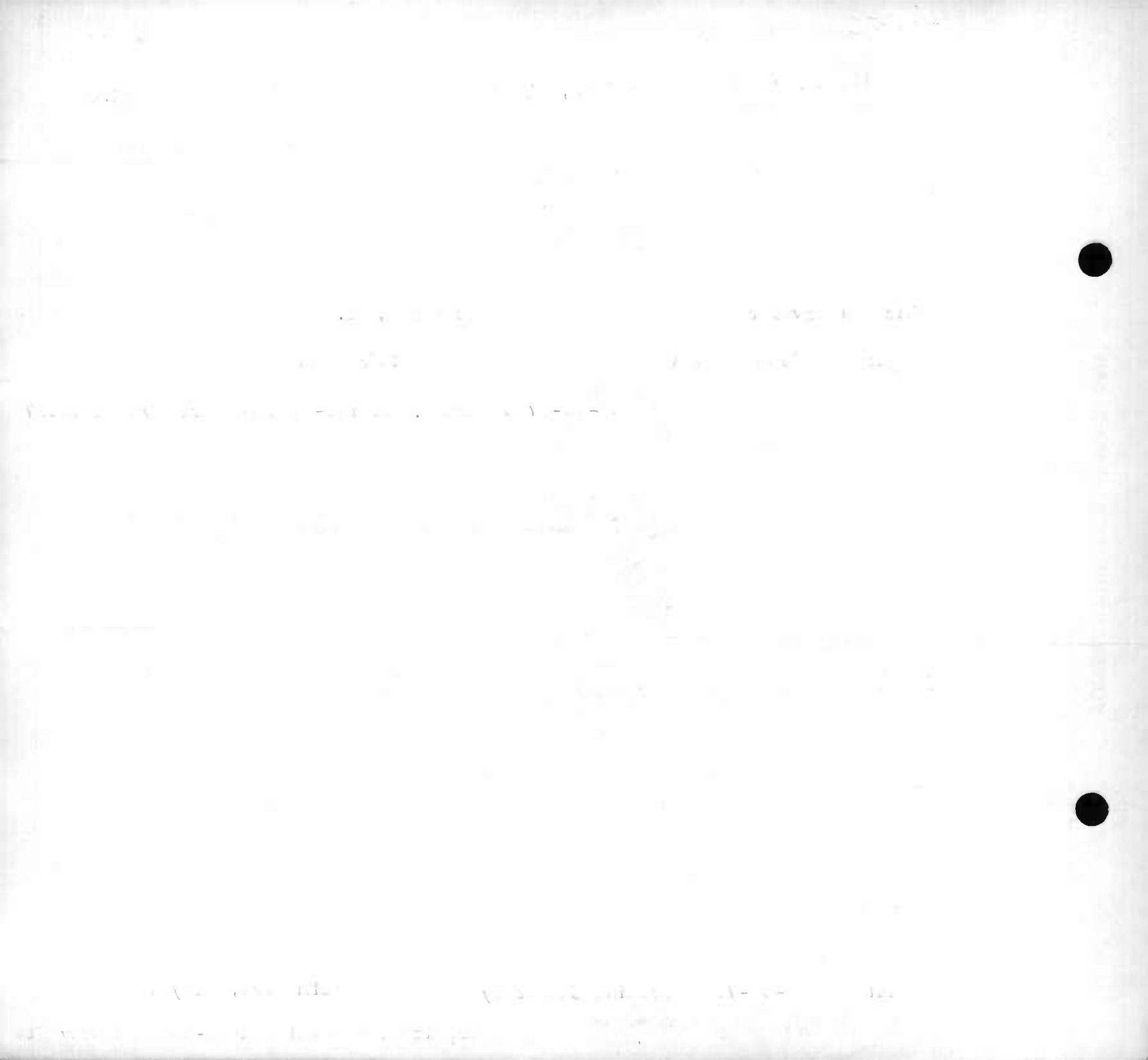
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 9019	
L-180 71 9019		BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		M.	
IDA C. LEVY		SEPT 22/71 11 A.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		2802	
3511 ELDORADO AVENUE		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
HOUSEWIFE		AT HOME		8-15-1892	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
ISAAC CAPLON		MOLLIE ?		79	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
NO		214-18-6155		BALTIMORE, MARYLAND	
17. INFORMANT		ADDRESS		12. CITIZEN OF WHAT COUNTRY?	
MR. MILTON CAPLON, 6208 FREDERICK AVENUE				USA	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE		instantaneous	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		16 yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II		Hypertension		16 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 2 Jan 1956 to 17 Sept 1971		that (I) (we) last saw the deceased alive on 17 Sept 1971		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED			
DR. MARVIN DAVIS		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
				8507 LIBERTY ROAD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		9-24-71		BETH TFILOH	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 28 1971		Robert E. Fisher, R.D.		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-252 71 9320		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9320	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HOSKINS EDGAR, JOHN</b>		2. DATE AND HOUR OF DEATH <b>9/25/71</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M. <b>1-40 AM</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL of BALTIMORE</b>		A. STATE <b>MARYLAND</b>		B. COUNTY <b>Baltimore</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 MARLAND</b>		C. CITY OR TOWN <b>MARYLAND</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>5-1-20</b>		9. AGE (In years lost birthday) <b>51 yrs</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Supervisor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Richmond, Va.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>Edgar John Hoskins</b>		14. MOTHER'S MAIDEN NAME <b>Stofreggen</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>24-18-1746</b>		17. INFORMANT <b>Sara S. Hoskins-2900 Bowers Avenue 21207</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>TRAUMATIC QUADRIPLÉGIA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>13 d.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) state the UNDERLYING CONDITION last		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Dislocation of cervical spine</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIO RESPIRATORY FAILURE</b>	
(C) <b>Bronchial Asthma</b>		years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION <b>9-13-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RESPIRATORY FAILURE</b>	
19A. DATE OF OPERATION <b>TRACHEOSTOMY</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2900 Bowers Ave 28-02</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx) <b>9-11-71 5 P.M.</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>fall</b>	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>HOUSE STAFF</b>	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-28-71</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1971</b>	
25B. NAME OF REGISTRAR <b>Arinagost Funeral Chapel-4600 Liberty Hts</b>		25C. FUNERAL DIRECTOR		25D. ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9021</u>	
BIRTH NO. <u>W-200 71 9021</u>		1. NAME OF DECEASED (Type or Print) <u>Blodwen Margaret Weiss</u>		2. DATE AND HOUR OF DEATH <u>Sept. 24, 1971</u> <u>12:35</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>US Public Health Service Hospital</u> <u>2X 3100 Wyman Parkway</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>901</u>			
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>7/24/07</u>		9. AGE (In years last birthday) <u>64</u>		10. Under 1 Yr. 11. Under 24 Hrs. Min. Months Days Hours	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hwf- Teacher Balto. City Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Thomas Llewellyn</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-12-0549</u>		17. INFORMANT <u>Mr Wm. J. Weiss 932 North Hill Rd.</u> <u>Records- US PHS Hospital, Balto, Md.</u>	
18. <u>124X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Bilateral pulmonary edema</u> <small>[This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.]</small>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Metastatic carcinoma</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of right breast</u> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Months</u> <u>1 yr.</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>22</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 8</u> 19 <u>71</u> to <u>Sept. 24</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Sept. 24</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert E. Belliveau, M.D.</u>				23B. DATE SIGNED <u>9/24/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert E. Belliveau, Surg (R)</u>				23D. ADDRESS <u>US PHS Hospital, Balto, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/27/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1971</u>			
25B. NAME OF FUNERAL HOME <u>Henry Sander &amp; Sons Inc.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Baltimore Maryland</u>			

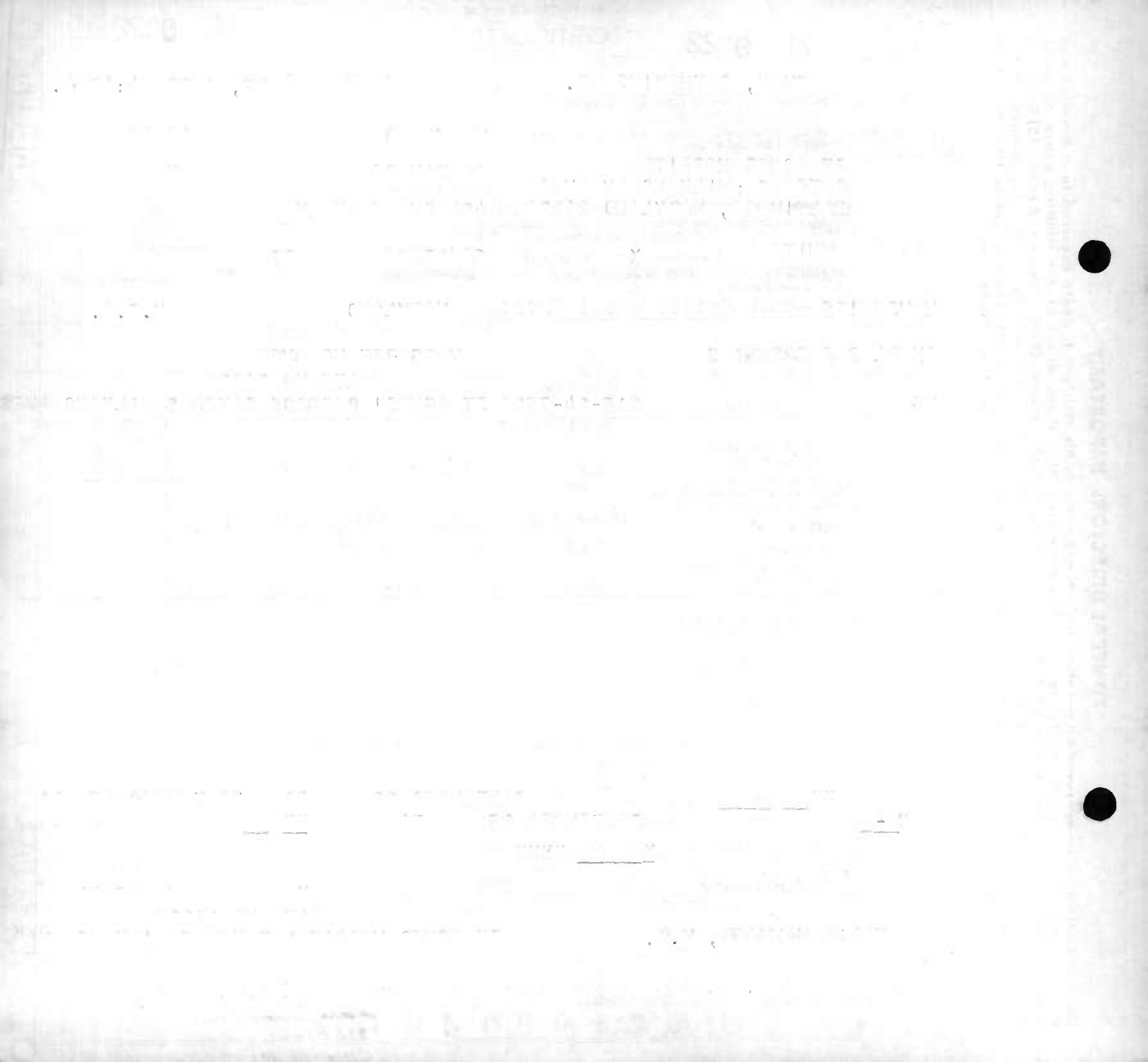
Robert B. Bellman (Jr.)



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

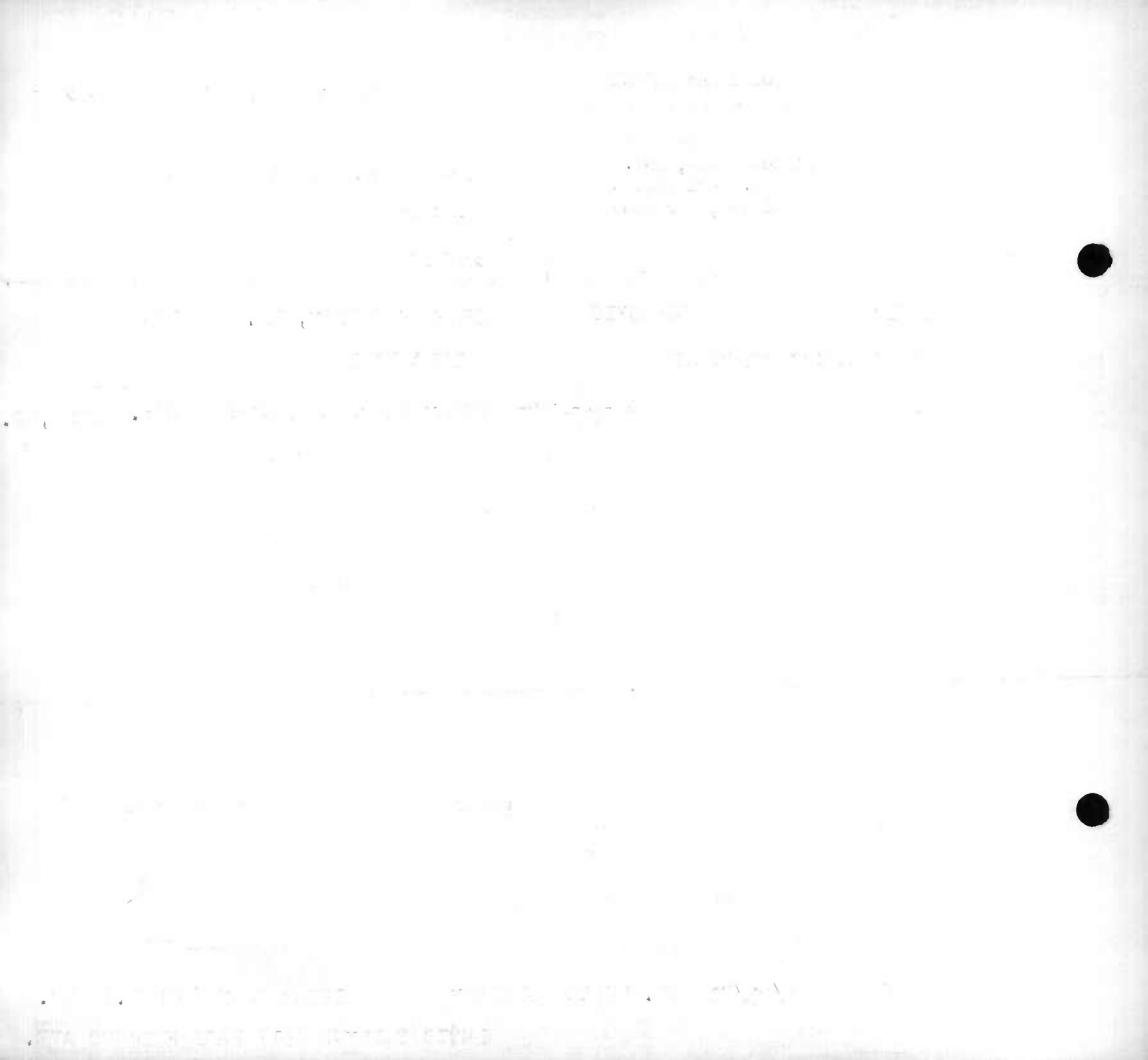
VS 150-REV. 1/1/68

Catonville, Md 21226



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9023</u>
BIRTH NO. <u>K-320 71 9023</u>				
1. NAME OF DECEASED (Type or Print) <u>Georgianna RITCHIE</u>		2. DATE AND HOUR OF DEATH <u>September 19, 1971</u> <u>7:45 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>90</u> <u>Midtown Home, Inc.</u> <u>808 St. Paul Street</u> <u>Baltimore, Maryland</u>		A. STATE <u>Md</u> B. COUNTY <u>1608</u>		
5. SEX <u>F</u>		6. RACE <u>B</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		8. DATE OF BIRTH <u>5/10/87</u>
13. FATHER'S NAME <u>JOHN WESLEY THOMPSON</u>		14. MOTHER'S MAIDEN NAME <u>LULA HALL</u>		9. AGE (In years lost birthday) <u>84</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-26-9680-A</u>		11. BIRTHPLACE (State or foreign country) <u>CHARLES COUNTY, MD.</u>
17. INFORMANT <u>PEGGY THOMPSON RAILROAD AVE. OWINGS MILLS, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
18. <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Cardio Respiratory Failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Seminal</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Heart Failure</u> (B) <u>Undetermined Cause</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes Mellitus</u> (C) _____		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>June 13</u> 19 <u>69</u> to <u>September 19</u> 19 <u>71</u> that (I) <del>was</del> last saw the deceased alive on <u>Sept 19</u> 19 <u>71</u> and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did not) view the body after death.				
23A. SIGNATURE <u>William D Appleford</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>William D Appleford</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9/23/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ST. LUKES CEMETERY</u>
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1971</u>		25B. NAME OF REGISTRAR <u>LEWIS T GYNN</u>		25C. FUNERAL DIRECTOR <u>4517 PARK HEIGHTS AVE.</u>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9024</u>	
J-525 71 9024				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>JOHNSON, JOSEPH CHESTER</u>		2. DATE AND HOUR OF DEATH <u>9/25/71</u> <u>705 P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2102</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1264 SARGENT ST</u>		F. ZIP CODE <u>21213</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/29/12</u>	9. AGE (In years last birthday) <u>58</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance man</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Federal Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>WILLIAM JOHNSON</u>		14. MOTHER'S M maiden NAME <u>Don Grooms</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u>		16. SOCIAL SECURITY NO. <u>212-38-7952</u>		17. INFORMANT <u>Mrs Nettie Johnson</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>INTRACEREBRAL HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>HYPERTENSION</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>DIABETES MELLITUS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>C.O.P.D.</u>					
19A. DATE OF OPERATION <u>9/21/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>9/21/71</u> to <u>9/26</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/26</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Jeffrey Samuel MD</u>		23B. DATE SIGNED <u>9/26/71</u>		23C. PHYSICIAN'S NAME (Type) <u>JEFFREY SAMUEL MD</u>	
23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/29/71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>East Lawn Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Howard Co. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1971</u>	
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>John P. Cowan &amp; Son Inc.</u>		25D. ADDRESS <u>Yellow St.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-420 71 9025		BALTIMORE CITY HEALTH DEPARTMENT		71 9025	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Ernest L. Click		Sept. 25 1971		8:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 48		A. STATE Maryland		B. COUNTY Carroll	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospt.		C. CITY OR TOWN Westminster		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER Route #2			
5. SEX Male	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-03-41	9. AGE (In years last birthday) 30	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY HEAD SHI, Co.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME ERNEST G. CLICK		14. MOTHER'S MAIDEN NAME RUTH SHINDLEDECKER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 213-40-2090		17. INFORMANT MRS. DORIS R. CLICK, WESTMINSTER RT#2, MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 201X I		CAUSE OF DEATH (A) IMMEDIATE CAUSE Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF: (B) Pulmonary Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (C) Hodgkins Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours 72 hours 8 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 3 1971 to Sept. 25 1971 that (I) (we) last saw the deceased alive on September 25 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard C. Keown MD.		23B. DATE SIGNED September 25, 1971		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) Richard C. Keown MD.		23D. ADDRESS Maryland General Hospital			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-29-71		24C. NAME OF CEMETERY or CREMATORY MEADOW BRANCH CEMETERY	
24D. LOCATION (City, town, or county) (State) WESTMINSTER, MD.		24E. DATE REC'D BY HEALTH DEPT. SEP 28 1971		24F. NAME OF REGISTRAR Paul E. Taylor	
24G. FUNERAL DIRECTOR J. E. Rogers Jr.		24H. ADDRESS Westminster, Md.			





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9026</u>	
<div style="display: flex; justify-content: space-between;"> <span><u>N-242</u> 71 9026</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Nuckles, Robert T.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>Sept. 22, 1971</u> <u>9 P</u> M.			
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1902</u>		C. CITY OR TOWN <u>BALTIMORE</u>	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>1512 MC HENRY ST.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-15-42</u>	9. AGE (In years last birthday) <u>28</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Maryland Cup Co</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia,</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>ROBERT FRANK NUCKLES</u>			
14. MOTHER'S MAIDEN NAME <u>BETTY</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u>			
16. SOCIAL SECURITY NO. <u>215-40-6988</u>		17. INFORMANT ADDRESS <u>Hospital Records</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Expanding Intercerebral mass</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 mos</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Congenital Heart Disease</u> <u>Meningitis, Cerebritis</u>		DUE TO, OR AS A CONSEQUENCE OF: <u>since birth</u> <u>1 mo</u>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO.</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>Sept 22</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/22</u> 19 <u>71</u> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Karen Oneill MD</u>				23B. DATE SIGNED <u>9/22/71</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<u>KAREN ONEILL, M.D.</u>		<u>Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-27-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Thomas J Kerry, Inc 1600 Hollins St</u>	

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 9027</u>	
<b>1. NAME OF DECEASED</b> (Type or Print) <u>MARGARET M. ETZEL</u>				<b>2. DATE AND HOUR OF DEATH</b> <u>9-25-71</u> <u>2 15</u> M.			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2401 EUTAW PL</u> <u>LAKE DRIVE NURSING HOME</u>				<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO</u> <u>5300</u> <b>C. CITY OR TOWN</b> <u>ESSEX</u> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>625 MARYLAND AVE</u>			
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1/4/88</u>	<b>9. AGE</b> (In years last birthday) <u>83</u>	<b>If Under 1 Yr.</b> Months: Days: Hours: Min.	<b>If Under 24 Hrs.</b> Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>H.W.</u>
<b>10B. KIND OF BUSINESS OR INDUSTRY</b>			<b>11. BIRTHPLACE</b> (State or foreign country) <u>MD.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		
<b>13. FATHER'S NAME</b> <u>ADAM REITER</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>ROSE DUNNIGAN</u>				
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			<b>16. SOCIAL SECURITY NO.</b> <u>214-07-1283</u>	<b>17. INFORMANT</b> <u>JOHN ETZEL</u>	<b>ADDRESS</b> <u>ABOVE</u>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <u>412.41</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>CAUSE OF DEATH</b> <u>CARDIAC ARREST</u> <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <u>ARTERIO-SCLEROTIC CARDIOVASCULAR disease</u> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <u>Chronic Bronch Syndrome</u> <b>(C)</b> <u>Arterio-sclerotic Cardiovascular disease</u>				
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>							
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>4-16</u> <u>1970</u> <b>to</b> <u>9-25</u> <u>1971</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>8-3</u> <u>1971</u> <b>and that in (my) (our) opinion death occurred on the date</b> <u>9-25-71</u> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <u>[Signature]</u> <u>MD.</u> DEGREE				<b>Attending Phys.</b> <input checked="" type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input type="checkbox"/>		<b>23B. DATE SIGNED</b> <u>9-25-71</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>MARCELINO F. RUBIENS</u> <u>MD.</u> DEGREE				<b>23D. ADDRESS</b> <u>7935 PETERS PATH GLEN BORNIE MD 21041</u>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>	<b>24B. DATE</b> <u>9/28/71</u>	<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>SACRED HEART</u>		<b>24D. LOCATION</b> (City, town, or county) (State) <u>BALTO. MD.</u>			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>SEP 28 1971</u>		<b>25B. NAME OF REGISTRAR</b> <u>[Signature]</u>		<b>25C. FUNERAL DIRECTOR</b> <u>[Signature]</u>		<b>ADDRESS</b> <u>300 Main Ave</u>	



1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
ALVIN DONALDSON		Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year		FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE B. COUNTY	
Male		Negro		September 23, 1971		10:35 A.M.		Maryland 1601	
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH		10. AGE (In years lost birthday)	
Male		Negro				Sept 3-1905		60	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
South Carolina		USA		Robert Donaldson		Railroad B		Arlene Boba	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		19. CAUSE OF DEATH		20. DATE OF OPERATION	
No		213-07-0622		Addie Thomas		Arteriosclerotic cardiovascular disease		2	
21. AUTOPSY? (Yes or No)		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		23. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		24. TIME (Month) (Day) (Year) (Hour)		25. INJURY OCCURRED	
yes						26. HOW DID INJURY OCCUR?		27. DATE REC'D BY HEALTH DEPT	
								SEP 28 1971	
28. NAME OF REGISTRAR		29. FUNERAL DIRECTOR		30. DATE		31. NAME OF CEMETERY or CREMATORY		32. LOCATION (City, town, or county) (State)	
Robert E. Taylor, M.D.		Richards F.H. Abbeville, S.C.		10-1-71		Camp Hill		South Carolina	
33. DATE OF OPERATION		34. CONDITION FOR WHICH OPERATION WAS PERFORMED		35. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		36. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		37. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
2									
38. TIME (Month) (Day) (Year) (Hour)		39. INJURY OCCURRED		40. HOW DID INJURY OCCUR?		41. DATE OF OPERATION		42. CONDITION FOR WHICH OPERATION WAS PERFORMED	
2		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				2			
43. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		44. ACTUAL SIGNATURE EXAMINER'S NAME (Type)		45. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		46. DATE SIGNED		47. DATE OF OPERATION	
Ronald N. Kornblum, M.D.						9/23/71		2	
48. DATE REC'D BY HEALTH DEPT		49. NAME OF REGISTRAR		50. FUNERAL DIRECTOR		51. DATE OF OPERATION		52. CONDITION FOR WHICH OPERATION WAS PERFORMED	
SEP 28 1971		Robert E. Taylor, M.D.		Richards F.H. Abbeville, S.C.		10-1-71			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9029</u>	
BIRTH NO. <u>W-310 71 9029</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>ELEANORA WHITBY</u>		2. DATE AND HOUR OF DEATH <u>9-22-71 4:00 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE JOHNS HOPKINS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>5-81</u>			
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1206 NOLAN CT.</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-2-21</u>	9. AGE (In years last birthday) <u>50</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	
13. FATHER'S NAME <u>JOHN SPRIGGS</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES PATTERSON</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Dorothy Horne</u>	
				ADDRESS <u>3401 E Lafayette St</u>	
18. <u>303.2 14180X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: <u>CHRONIC AND ACUTE ALCOHOLISM &amp; ASCITIES AND HYPOKALEMIA</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ANEMIA, CA OF CERVIX S/P IRRADIATION &amp; HEMORRHAGIC CYSTITIS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>WKS.</u> <u>MANY YEARS</u> <u>1 yr.</u>	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>MARCH</u> 19 <u>70</u> to <u>SEPT 22</u> 19 <u>71</u> that (I) <u>(we)</u> last saw the deceased alive on <u>SEPT 22</u> 19 <u>71</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>John A. Nesbitt, III</u>				23B. DATE SIGNED <u>9-22-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, III</u>				23D. ADDRESS <u>601 N. BROADWAY BALT., MD. 21205</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		24B. DATE <u>9-27-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cmt</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>		25A. DATE RECEIVED BY HEALTH DEPT. <u>SEP 28 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Robert E. Taylor, Jr.</u>			
25D. ADDRESS					

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9030

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>SUBER RITA</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>46 LUTHERAN HOSPITAL</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 23, 1971 12:30 A.</b> M.			
6. SEX <b>Female</b>				7. RACE <b>Negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>April 9-1957</b>				10. AGE (In years last birthday) <b>20</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>	
12. CITIZEN OF <b>USA</b>				13. FATHER'S NAME <b>Joseph Jacobs</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME <b>Edna Mae Bentley</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>X</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Clairine Wilks</b>				19. ADDRESS <b>304 N 736.9</b>			
20. CAUSE OF DEATH <b>Hepatitis and Bronchopneumonia complicating Intravenous Narcotism</b>				21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) DUE TO, OR AS A CONSEQUENCE OF:				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:				(D) DUE TO, OR AS A CONSEQUENCE OF:			
22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
24A. DATE OF OPERATION <b>2</b>				24B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
25A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				25B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)			
25C. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				25D. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
25E. HOW DID INJURY OCCUR?				25F. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
26. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				27. ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>			
28. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				29. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
30. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				31. DATE SIGNED <b>9/23/71</b>			
32A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				32B. DATE <b>9-27-71</b>			
32C. NAME OF CEMETERY or CREMATORY <b>Mount Vernon Cent</b>				32D. LOCATION (City, town, or county) (State) <b>Balto Md</b>			
33A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1971</b>				33B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>			
33C. FUNERAL DIRECTOR <b>Clayton Oriskany</b>				33D. ADDRESS <b>1001 Brantley Ave</b>			

9/29/71 - Cause of Death -

Drug Addiction

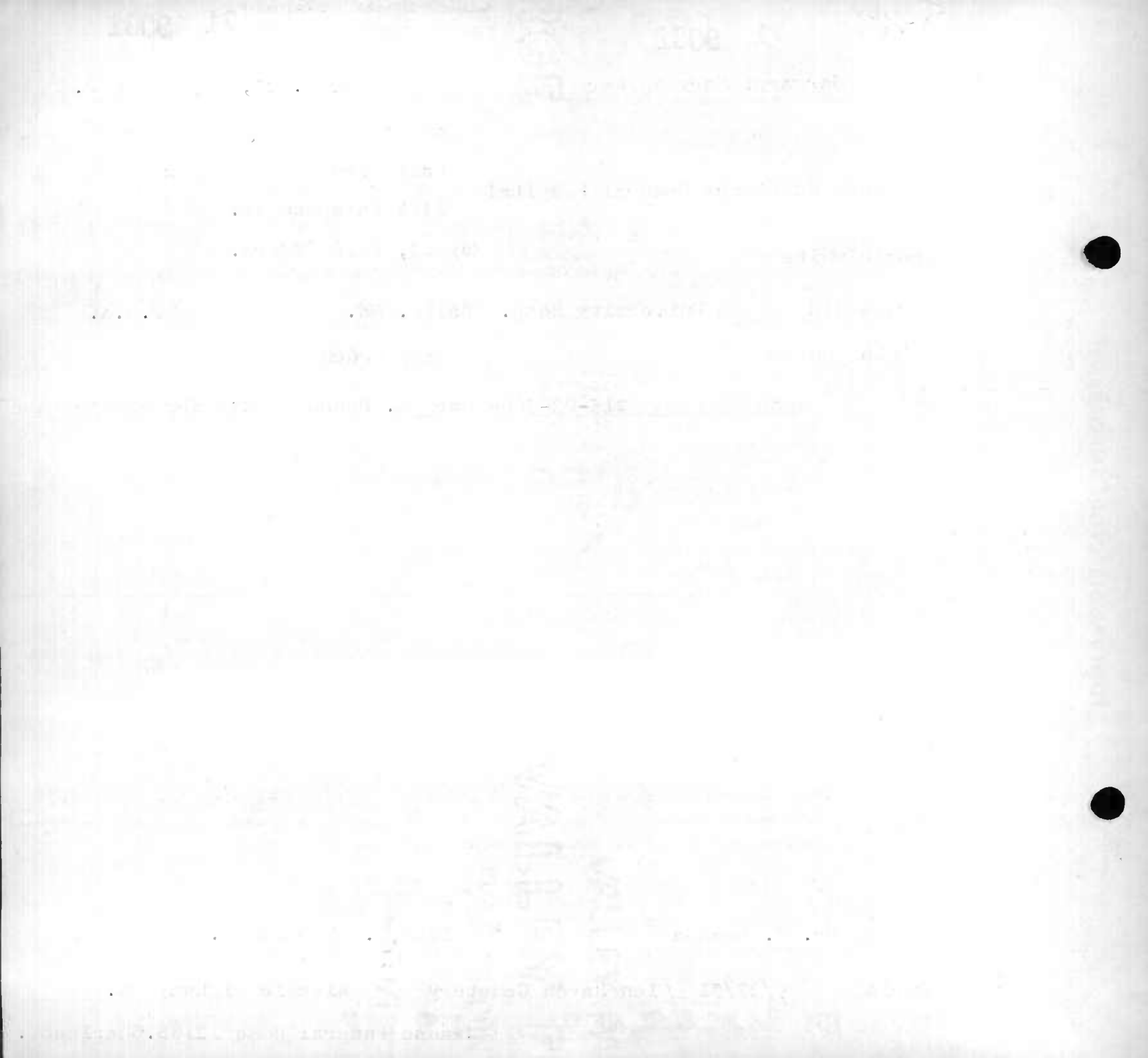
complicated by septicemia  
due to injection of a dirty  
needle - Information from

Med. Exam - Dr. Kornblum via phone  
9

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 9031</b>	
BIRTH NO. <b>S-126 71 9031</b>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Margaret Mary Spiker</b>			2. DATE AND HOUR OF DEATH <b>Sept. 23, 1971 9 P.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>43 South Baltimore General Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2302</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1412 Patapsco St.</b>		
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 13, 1916</b>	9. AGE (In years last birthday) <b>55 yrs.</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurses Aid</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>University Hosp.</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
13. FATHER'S NAME <b>John Hutson</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no none</b>			14. MOTHER'S MAIDEN NAME <b>Mary Couch</b>		
16. SOCIAL SECURITY NO. <b>215-03-5069</b>			17. INFORMANT <b>Mary L. Donahue</b> ADDRESS <b>122M Warwickshire Lane</b>		
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Ante Myocardial infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>1969</b> to <b>Sept. 23, 1971</b> , that (I) (we) last saw the deceased alive on <b>Sept. 21, 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. R. Lozada</b>			23B. DATE SIGNED <b>9/25/71</b>		
23C. PHYSICIAN'S NAME (Type) <b>Dr. R. Lozada</b>			23D. ADDRESS <b>1228 S. Charles St.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/27/71</b>		24C. NAME of CEMETERY or CREMATORY <b>Glen Haven Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Ritchie Highway Md.</b>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD.</b>		25C. FUNERAL DIRECTOR <b>Krause Funeral Home</b>	
25D. ADDRESS <b>1216 S. Charles St.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

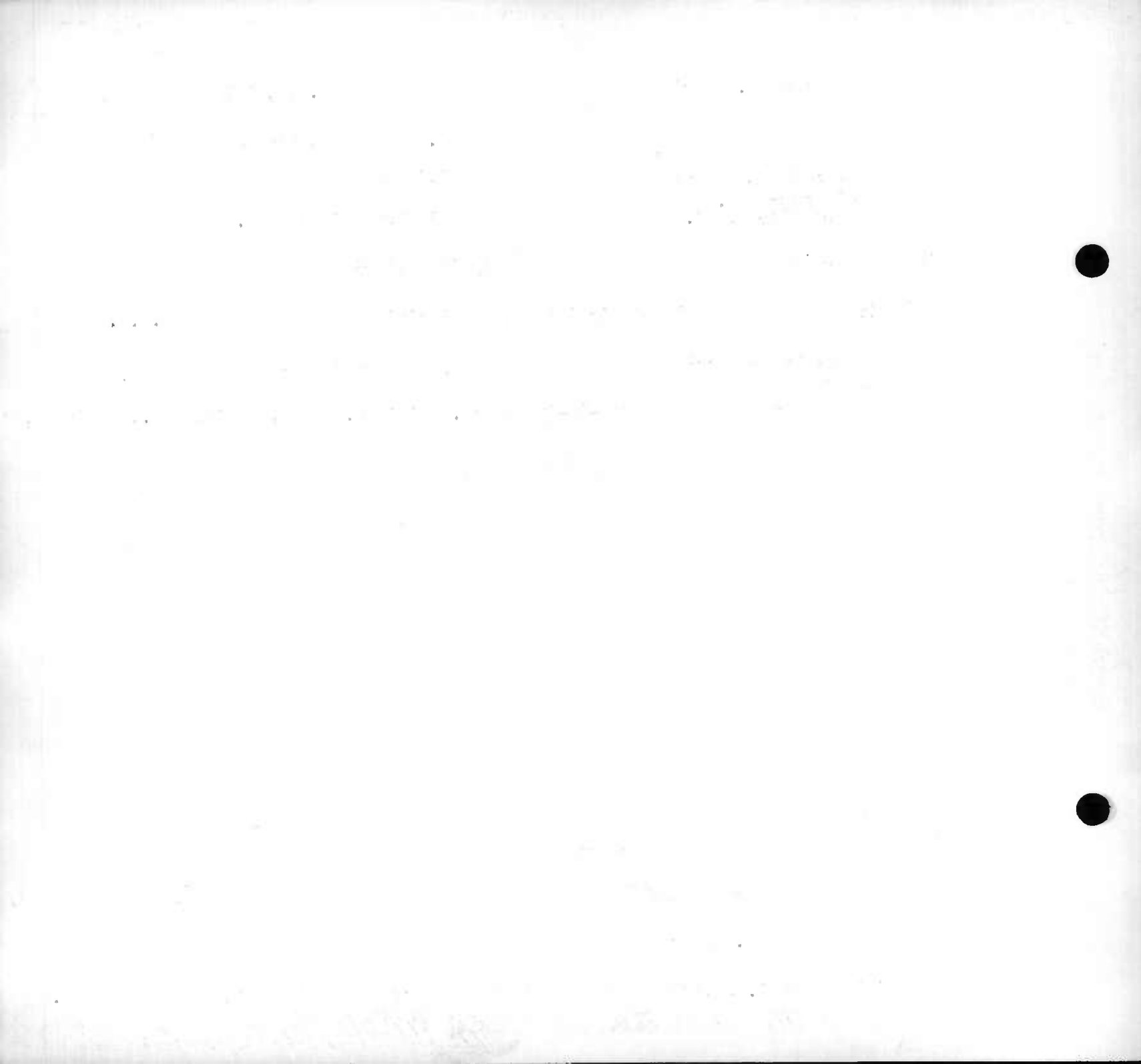
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">71</span> <span style="font-size: 1.2em;">9032</span>	
<div style="display: flex; justify-content: space-between;"> <span>P-645</span> <span>BIRTH NO. <span style="font-size: 1.2em;">71-17412</span> <span style="font-size: 1.2em;">71</span> <span style="font-size: 1.2em;">9032</span></span> </div>					
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Baby Boy Perlman</span>			<b>2. DATE AND HOUR OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span><span style="font-size: 1.2em;">9-25-71</span></span> <span><span style="font-size: 1.2em;">2:50</span> A.M.</span> </div>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>  <span style="font-size: 1.5em;">37</span> <span style="font-size: 1.2em;">Mercy Hospital</span> </div> <div> <b>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b> </div> </div>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md</span> B. COUNTY <span style="font-size: 1.5em;">2765</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>			<b>6. RACE</b> <span style="font-size: 1.2em;">White</span>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>
<b>8. DATE OF BIRTH</b>		<b>9. AGE</b> (In years last birthday)		<b>10. UNDER 1 Yr.</b> Months <input type="checkbox"/> <b>Days</b> <input type="checkbox"/> <b>Under 24 Hrs.</b> Hours <input type="checkbox"/> <b>Min.</b> <span style="font-size: 1.2em;">25 min</span>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)
<b>12. CITIZEN OF WHAT COUNTRY?</b>			<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Harold Perlman</span>		
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Phyllis Conel</span>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b>		<b>ADDRESS</b>	
<b>18. CAUSE OF DEATH</b>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">25 min.</span>	
<b>(A) IMMEDIATE CAUSE</b> <span style="font-size: 1.2em;">Cardiorespiratory failure</span> DUE TO, OR AS A CONSEQUENCE OF:					
<b>(B) Marked Prematurity</b> DUE TO, OR AS A CONSEQUENCE OF:					
<b>(C) Premature Rupt. of Membrs. &amp; seps.</b> DUE TO, OR AS A CONSEQUENCE OF:					
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">YES</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">9/25/71</span> <span style="font-size: 1.2em;">2:25 AM</span> 19 <span style="font-size: 1.2em;">71</span> to <span style="font-size: 1.2em;">9/25/71</span> <span style="font-size: 1.2em;">2:50 AM</span> 19 <span style="font-size: 1.2em;">71</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">9/25/71</span> 19 <span style="font-size: 1.2em;">71</span> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">[Signature]</span> <span style="font-size: 1.2em;">MD</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">9/27/71</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type)				<b>23D. ADDRESS</b>	
<b>ANATOMY BOARD OF MARYLAND</b>					
<b>24A. BURIAL - CREMATION, REMOVAL</b> (Specify)		<b>24B. DATE</b>		<b>24C. NAME of CEMETERY or CREMATION</b>	
<span style="font-size: 1.2em;">[Mark]</span>		<span style="font-size: 1.2em;">9/28/71</span>		<span style="font-size: 1.2em;">JOHNS HOPKINS MEDICAL SCHOOL</span>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b>		<b>25B. NAME OF REGISTRAR</b>		<b>25C. FUNERAL DIRECTOR</b>	
<span style="font-size: 1.2em;">SEP 28 1971</span>		<span style="font-size: 1.2em;">Robert E. Taylor, Jr.</span>		<span style="font-size: 1.2em;">MORTUARY SERVICE - BCHD</span>	

1333 Roland Hyatt Ave

NE2

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>71 9033</b>	
BIRTH NO. <b>71 9033</b>		2. DATE AND HOUR OF DEATH <b>Sept. 21, 1971 10:35 A.M.</b>	
1. NAME OF DECEASED (Type or Print) <b>John J. Davis</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 House In The Pines Belvedere Ave. Baltimore, Md.</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 28, 1901</b> 9. AGE (in years last birthday) <b>70</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Calvert Distillerys</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Robert Davis</b>		14. MOTHER'S MAIDEN NAME <b>Mary Alice Powell</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-05-2056A</b>	
17. INFORMANT <b>Mr. Philip H. Sachs</b>		ADDRESS <b>10 Light St., Baltimore, Md.</b>	
18. <b>153.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Denervolized carcinoma</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cancer of colon.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 months approx. 1 year.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Initially medical examined <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <b>June 1 1971</b> to <b>Sept 21 1971</b> that (I) (we) last saw the deceased alive on <b>Sept 17 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Alan B Cohen</b>		23B. DATE SIGNED <b>Sept 22, 1971</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr Alan B. Cohen</b>		23D. ADDRESS <b>3501 ST Paul ST 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Sept. 23, 1971</b>	
24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Frank A. Newell, Baltimore, Md.</b>		ADDRESS	





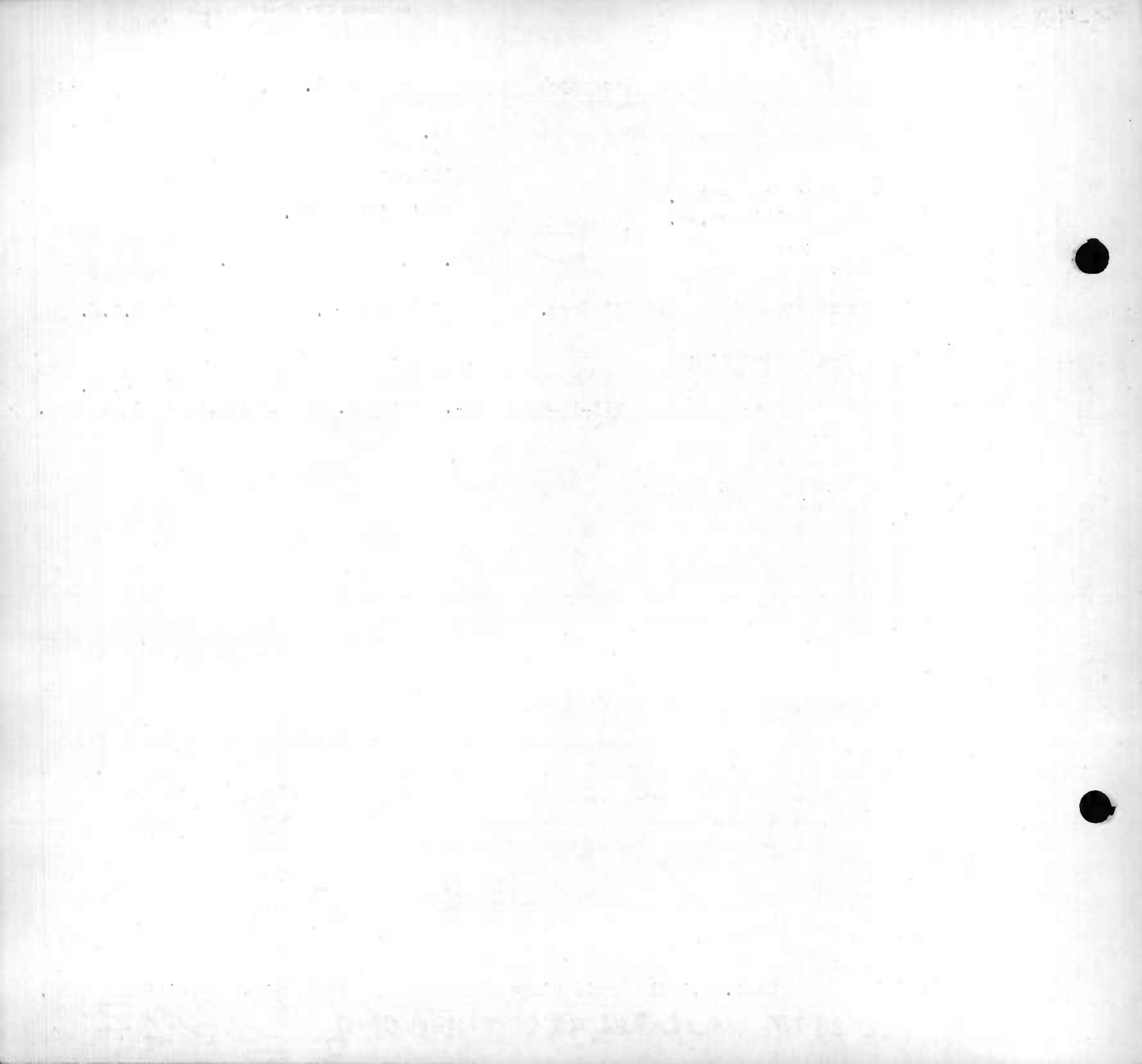
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **71 9034**

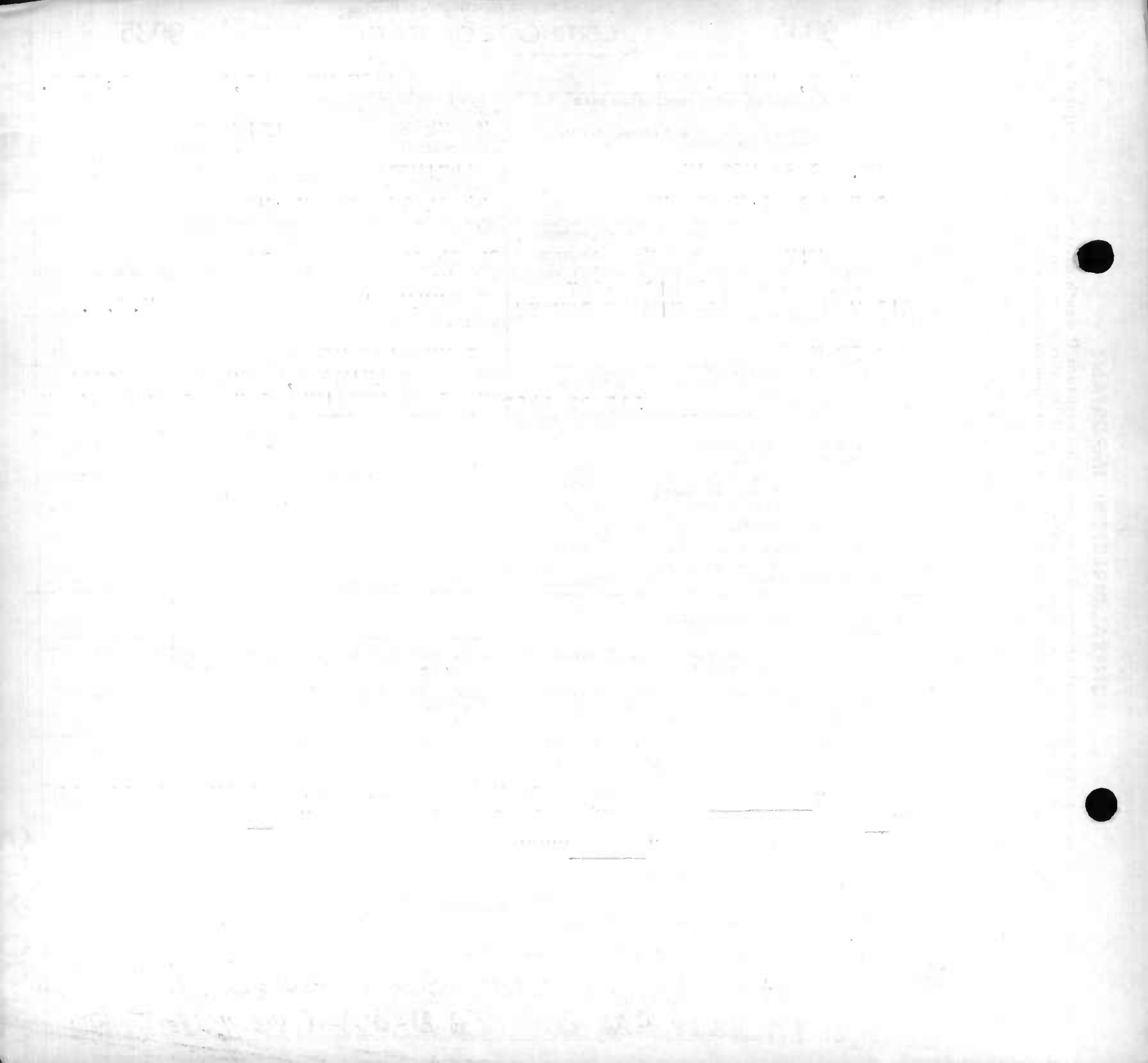
BIRTH NO. <b>71 9034</b>		1. NAME OF DECEASED (Type or Print) <b>Chester LeRoy Blackstock</b>		2. DATE AND HOUR OF DEATH <b>Sept. 22, 1971 1:05 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>00 5604 Winner Ave. Baltimore, Md.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2719</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b> 6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 26, 1915</b> 9. AGE (In years last birthday) <b>56 yrs.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oil Burner Mechanic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Gulf Oil Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George Blackstock</b>		14. MOTHER'S MAIDEN NAME <b>Mary Esther Ford</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>213-10-9998</b>		17. INFORMANT ADDRESS <b>Baltimore, Md.</b> <b>Mrs. Dorothy E. Blackstock, 5604 Winner Ave.</b>	
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Heart Disease 5 years</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic Heart Disease</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11:30 1968</b> to <b>9-21 1971</b> , that (I) (we) last saw the deceased alive on <b>2-11 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Franklin E. Leslie</b> DEGREE				23B. DATE SIGNED <b>9-22-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Franklin E. Leslie</b> DEGREE				23D. ADDRESS <b>3501 St. Paul St. - Balto Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Sept. 24, 1971</b>		24C. NAME of CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Pikesville</b>		24E. BALTIMORE <b>Baltimore</b>		24F. STATE <b>Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD.</b>		25C. FUNERAL DIRECTOR <b>Frank D. Newell</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 9035				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X REG. NO. 71 9035	
1. NAME OF DECEASED (Type or Print) KANE, JOHN LEROY				2. DATE AND HOUR OF DEATH SEPTEMBER 23, 1971 7:15 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 5300					
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL CATON & WILKENS AVE				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 24 CLARENDON AVENUE				5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICEMAN				10B. KIND OF BUSINESS OR INDUSTRY POLICE DEPT BALTIMORE COUNTY		8. DATE OF BIRTH 07 04 92		9. AGE (In years last birthday) 79	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JOSEPH KANE				14. MOTHER'S MAIDEN NAME CATHERINE HOWARD					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I				16. SOCIAL SECURITY NO. 213 32 1400		17. INFORMANT BALTIMORE, MARYLAND ADDRESS 21229 ST AGNES HOSPITAL CATON & WILKENS AVE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Cardiogenic shock (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute enterosigmoidal MI (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 3 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 21 19 71 to SEPTEMBER 23 1971 that (X) (we) last saw the deceased alive on SEPTEMBER 23 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Joseph Apter, M.D.				DEGREE		23B. DATE SIGNED 9/24/71		23C. PHYSICIAN'S NAME (Type) Joseph Apter, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE SEP 27 1971		24C. NAME OF CEMETERY OR CREMATORY Daniel Ridge Center		24D. LOCATION (City, town, or county) (State) Pikesville Balt. Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 28 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Frank H. Newell, Inc.		ADDRESS 1100 REIST. RD.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 9036</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>M-255 71 9036</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Grace Ramsey McMains		September 23, 1971 3:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
00 Carlisle Apts 110 University Pkwy		Maryland		1201	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F		W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Osteopathic Physician				9. AGE (In years last birthday) 72	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday) 72	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				ADDRESS	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Myocardial Infarct		weeks	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Arteriosclerotic Cardio-Renal Disease 1 yr or more			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 64 to September 23 1971, that (I) (we) last saw the deceased alive on September 22 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Newland Edward Day M.D.		September 23, 1971			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		4-E-33rd St Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
		9/24/71		Anatomy Board Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 28 1971		Robert E. Jabez, Jr. D O O		GEN L. SCHWAB, 2101 FREDERICK, AVE	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-536 71 9037		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9037	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LEONARD L. SAUNDERS</b>		2. DATE AND HOUR OF DEATH <b>SEPT 24, 1971 P. 20 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME AND HOSPITAL</b> <b>35</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2642</b>	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BAKERY</b>		8. DATE OF BIRTH <b>8-28-1911</b> 9. AGE (in years lost birthday) <b>60</b> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
13. FATHER'S NAME <b>JAMES W. SAUNDERS</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN GRIBLEN</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b> 12. CITIZEN OF WHAT COUNTRY? <b>AMER.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-03-2930</b>		17. INFORMANT <b>ALMA CRAWLEY, 7435 DORWARD RD. 21222</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiopneum Shock</b> <b>Renal Shutdown</b> <b>Acute M.I.</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE - DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 21</b> 19 <b>71</b> to <b>Sept 24</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>Sept 23</b> 19 <b>71</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>S. P. GEORGE M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Sept 24, 1971</b>	
23C. PHYSICIAN'S NAME (Type) <b>S. P. GEORGE</b>		23D. ADDRESS <b>Church Home &amp; Hospital.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>28 Sept 71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEMORIAL PK.</b>	
24D. LOCATION <b>BALTO. CO., MD.</b>		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR <b>WILSON FUNERAL HOME, BALTO., MD. 21206</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1971</b>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>WILSON FUNERAL HOME, BALTO., MD. 21206</b>	





# FUNERAL DIRECTOR: IMPORTANT

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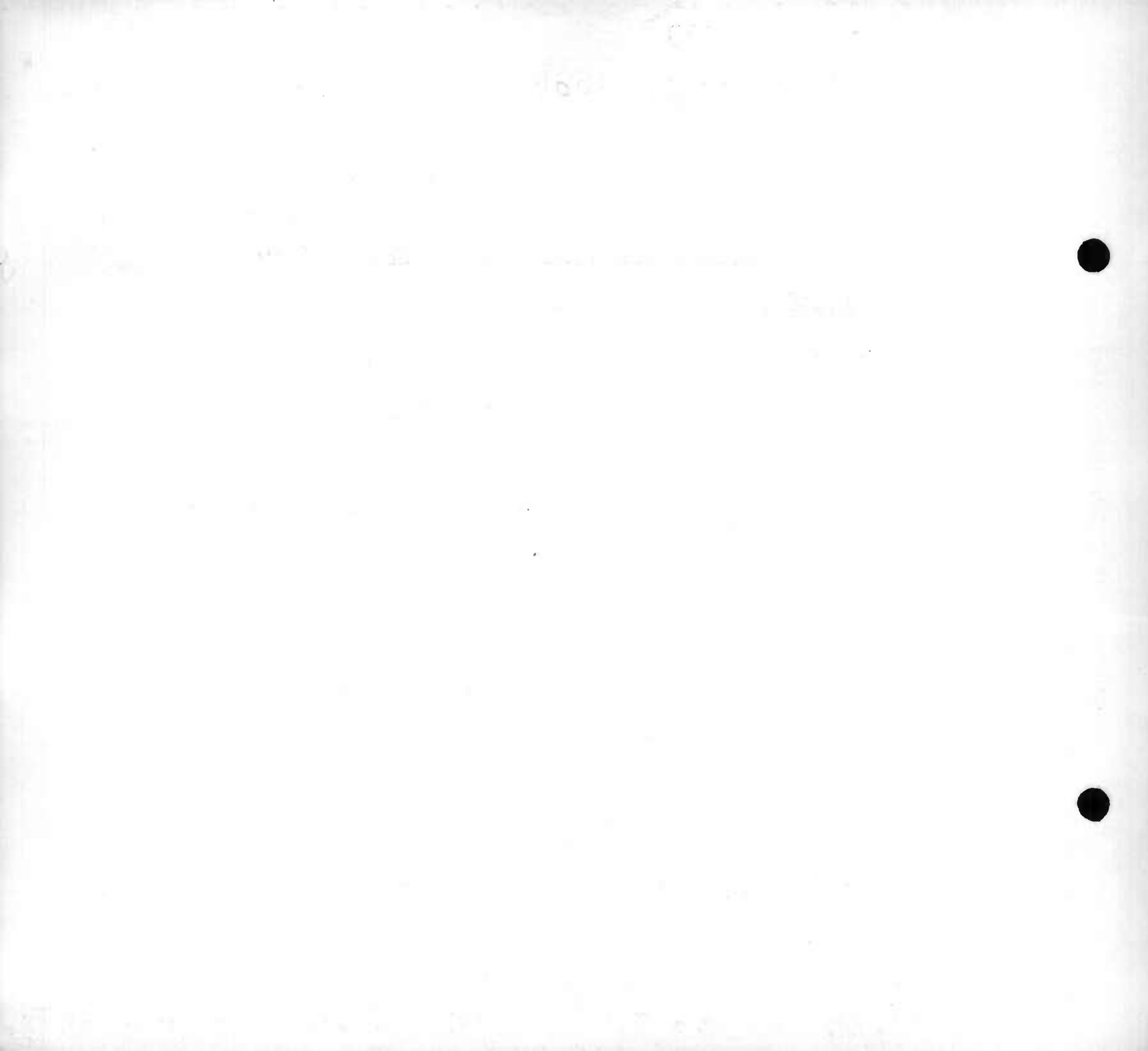
S-655 71 9038		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 71 9038	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		5. SEX		6. RACE	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
70		Gould Convelescence		Dundalk		5300	
E. STREET AND NUMBER		2906 DUNMANWAY		8. DATE OF BIRTH		9. AGE (In years last birthday)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		Aug 18 1889		82	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		New York			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Lorus Sherman				17. INFORMANT		ADDRESS	
				Robert Sherman		6644 Lock Hill	
18. 156.1 I		CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Carcinoma of Liver		10 weeks	
ANTECEDENT CAUSES		(B) Bile ducts DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		A-S-C-V-Suscept		5 yrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from Feb 6 1971 to Apr 6 1971		that (I) last saw the deceased alive on Sept 17 1971		and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. PHYSICIAN'S NAME (Type)		23C. DATE SIGNED			
M.B. Davis		M.B. Davis M.D.		9/26/71			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Removal		Sept 27/71		Matuschen An		Matuschen New Jersey	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 28 1971		Robert E. Taylor, M.D.		Edmund J. Taylor		4210 Blue	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 9039	
A-352 71 9039		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOHN ADAMS (ADOMAITIS)		SEPT. 26, '71 11:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
UNIV. OF MARYLAND HOSPITAL		MD.			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		38 S. PARKIN ST.		21201	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
M	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	01/14/80	91	11 Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Carpenter		In Self		Lithuania	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Casper Adams		Unknown		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
<input checked="" type="checkbox"/>				HOSPITAL CHART (E.R.)	
18. 412.4 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		IMMEDIATE	
(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)		PULMONARY EMBOLISM			
DUE TO, OR AS A CONSEQUENCE OF:		A.S.C.V.D. and C.O.P.D.			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No		4			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Warren P. Magid, M.D.		9/26/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
WARREN P. MAGID, M.D.		UNIV. HOSP., E.R.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		9/29/71		Gardens of Peace Cem.	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
Baltimore Md.		John P. ...		901 Hollins St. Balto. Md. 21202	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 28 1971		John P. ...		John P. ...	



BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			REG. NO. 71 9040
BIRTH NO.			
1. NAME OF DECEASED (Type or Print) FRANCES C. DURBORROW		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BON SECOURS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour September 22, 1971 8:45 P. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY BALTO 5300		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH June 17-1911	10. AGE (In years last birthday) 60	11. UNDER 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William F. BLISLINE	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR		15. MOTHER'S MAIDEN NAME MARY EISEL	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 218-03-6424	
18. INFORMANT MRS. MARY RALEY-1201 DORCHESTER RD		ADDRESS	
19. 412.41 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/23/71			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/17/71	
24C. NAME OF CEMETERY or CREMATORY MT. OLIVET CEM.		24D. LOCATION (City, town, or county) (State) BALTO. CITY M.D.	
25A. DATE REC'D BY HEALTH DEPT. SEP 28 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR FARLEY CAVANAUGH		ADDRESS 6601 FREDERICK AVE	

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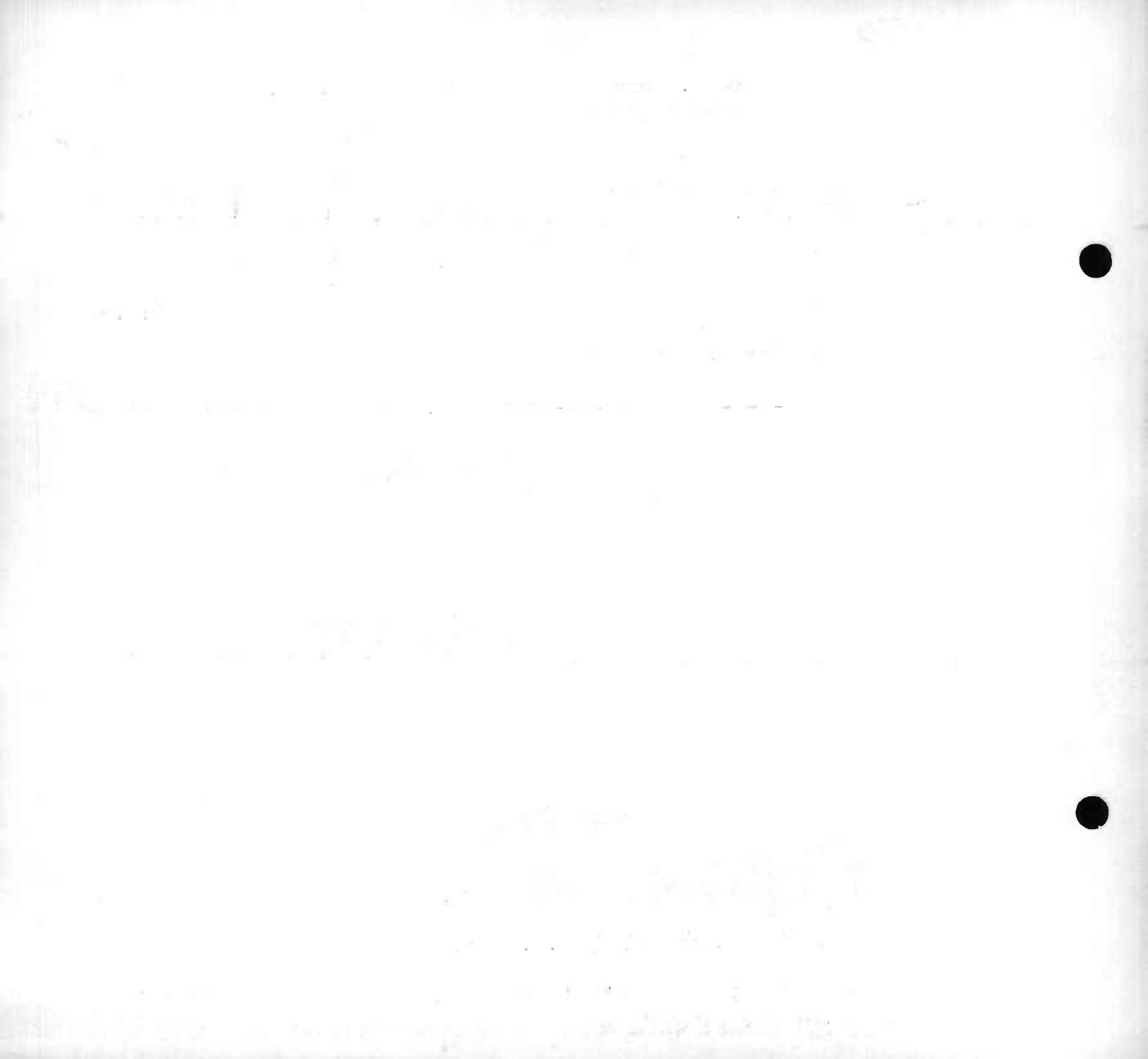
WILLIAM A. BENTLEY

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WILLIAM A. BENTLEY

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 9041	
D-500				71 9041	
BIRTH NO.				71 9041	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Anna L. Dunn			Sept. 27, 1971 1612 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
90 Long Green Nursing Home Balto, Md.			Maryland 401		
5. SEX			6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Female			White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH			9. AGE (In years lost birthday)		10. CITIZEN OF WHAT COUNTRY?
Oct. 24 1889			81 yrs		U.S.A
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Maryland			U.S.A		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Charles R. Conolley			Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No - - -			063-01-3323		21211 Mrs. Elaine Ivins 1306 Dellwood Ave
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II			Diabetes		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from Sept 26 1971 to Sept 27 1971 that (I) (we) last saw the deceased alive on Sept 26 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)
William G. Helfrich M.D.			9-27-71		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23D. ADDRESS			23E. DATE REC'D BY HEALTH DEPT.		
5006 Roland Avenue			SEP 28 1971		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME OF CEMETERY OR CREMATORY
Cremation			9/27/71		Greenmount Cemetery
24D. LOCATION (City, town, or county) (State)			24E. FUNERAL DIRECTOR ADDRESS		
Baltimore, Maryland			Donovan Funeral Home 3818 Roland Ave		





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P-326 71 9042

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9042

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM ALLEN PETTIGREW</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>SEPT 23 1971</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 JOHNS HOPKINS HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 23, 1971 7:30 AM</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>4-8-1884</b>		10. AGE (In years lost birthday) <b>87</b>	
11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		15. MOTHER'S MAIDEN NAME <b>Florida ?</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>218-12 0235A</b>	
18. INFORMANT <b>William H. Pettigrew</b>		ADDRESS <b>23 B Lafayette, Anna, Md</b>	
19. <b>412.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>no</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9/23/71</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-27-1971</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Pine Lawn Memorial Pk</b>		24D. LOCATION (City, town, or county) (State) <b>Annapolis A.A. Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, Jr.</b>	
25C. FUNERAL DIRECTOR <b>C.E. Hicks</b>		ADDRESS <b>111 1922 Forest Drive Anna, Md</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>71 9043</b>
P-362 71 9043 BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>PETERSON, HENRY</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <b>Sept. 26 1971 10:00 PM M.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hosp. of Maryland</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1510</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>M</b>		6. RACE <b>C</b>		E. STREET AND NUMBER <b>4020 Garrison BLVD.</b>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-20-12</b>		9. AGE (In years last birthday) <b>59</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>DAVIS Chemical Supply S.C.</b>		11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>249-14-4442</b>		17. INFORMANT <b>Florence Peterson</b>
18. <b>1977 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Ca of Liver 1 Mo. E</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>Aug. 17 1971</b> to <b>Sept. 26 1971</b> that (I) (we) last saw the deceased alive on <b>Sept. 26 1971</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Y3 Kim</b>		23B. DATE SIGNED <b>Sept 26, 1971</b>		23C. PHYSICIAN'S NAME (Type) <b>YOUNG Sook Kim, M.D.</b>
23D. ADDRESS <b>Lutheran Hosp. of Maryland</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>9-30-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Carver Mem. Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Laurel Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Jaber</b>		25C. FUNERAL DIRECTOR <b>Jeff F.H. 1701 - Laurens</b>

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9044</u>	
<div style="display: flex; justify-content: space-between;"> <span><b>S-530</b></span> <span><b>71 9044</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LILLIE MAE SMITH		9/24 4:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY BALTIMORE		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1005 MCKEEN AVE.		
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/27/10	9. AGE (In years last birthday) 61	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			11. BIRTHPLACE (State or foreign country) Balto. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CHARLES BARNES			14. MOTHER'S MAIDEN NAME HELEN PARKER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lillie Marcelle Thompson
					ADDRESS Same
18. CAUSE OF DEATH					
153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE PNEUMONIA					
DUE TO, OR AS A CONSEQUENCE OF:					
(B) WIDESPREAD METASTATIC CARCINOMA					
DUE TO, OR AS A CONSEQUENCE OF:					
OR COLON					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 9/22 19 71 to 9/24 19 71 that (we) last saw the deceased alive on 9/24 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert C. Bast, Jr. MD				23B. DATE SIGNED 9/24/71	
23C. PHYSICIAN'S NAME (Type) ROBERT C. BAST, JR. MD				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-27-71		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
				24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE RECD BY HEALTH DEPT. SEP 28 1971		25B. NAME OF REGISTRAR Robert E. Bailey, M.D.		25C. FUNERAL DIRECTOR MOP Ludens St	
				ADDRESS Morton & Dyett F.I.	

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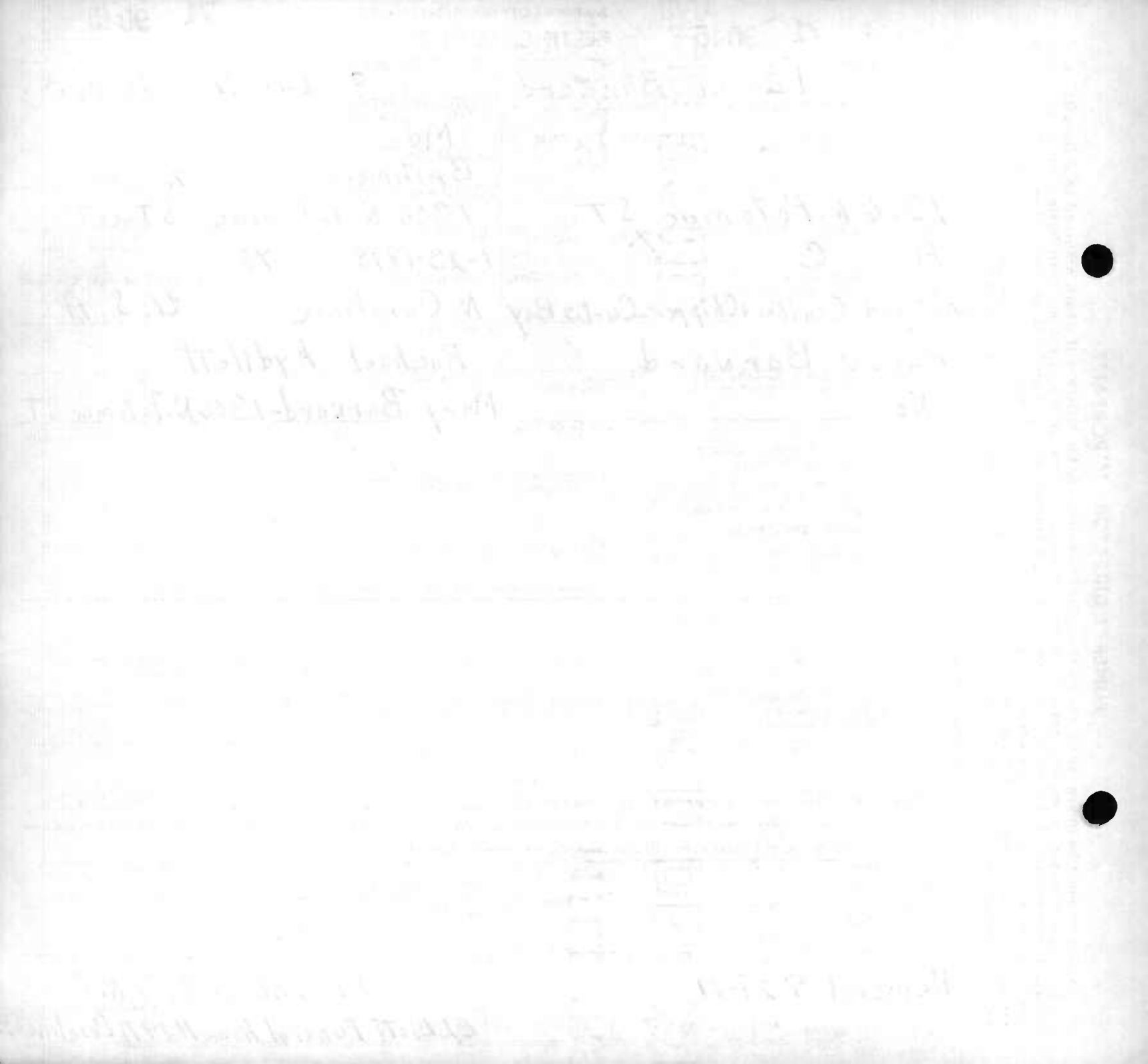
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 9045	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>Lucian Barnard</b>			2. DATE AND HOUR OF DEATH <b>9-14-71 10:45 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>843</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b>			C. CITY OR TOWN <b>Baltimore</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1306 N. Potomac St.</b>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>M</b>			6. RACE <b>C</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>1-23-1893</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Caulker &amp; Chipper-Curtis Bay</b>			9. AGE (in years last birthday) <b>78</b>		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>		
13. FATHER'S NAME <b>Aaron Barnard</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			14. MOTHER'S MAIDEN NAME <b>Rachael Aydllett</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Mary Barnard-1306 N. Potomac St.</b>		
18. <b>412.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive Cardiac Vascular Disease</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Disease</b>		
(B) DUE TO, OR AS A CONSEQUENCE OF:			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 3 1969</b> to <b>Sept 24 1971</b> that (I) (we) last saw the deceased alive on <b>March 3 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Frederick K. Adams</b>				23B. DATE SIGNED <b>Sept 28-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>FREDERICK K. ADAMS</b>				23D. ADDRESS <b>12227 Caroline St 21213</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>9-29-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Elizabeth City N.C.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>ELIZABETH CITY N.C.</b>	
25D. ADDRESS <b>SEP 28 1971</b>					





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525 71 9046		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9046	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Jarvis JOHNSON, LUCILLE</u>			2. DATE AND HOUR OF DEATH <u>SEPT. 26 1971</u> <u>3:07 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 SINAI HOSPITAL BALTIMORE</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>2802</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>3412 Woodbine Ave</u>		
5. SEX <u>M.</u>	6. RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-7-07</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Robert Scott</u>			14. MOTHER'S MAIDEN NAME <u>Korea Harris</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-20-6177</u>	17. INFORMANT ADDRESS <u>Theodore Johnson 3412 Woodbine Ave</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>GRAM NEGATIVE SEPTICEMIA</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>CHRONIC PYELONEPHRITIS</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) <u>CHRONIC RENAL FAILURE</u>		
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (this hospital) attended the deceased from <u>SEPT. 22</u> 19 <u>71</u> to <u>SEPT. 26</u> 19 <u>71</u> that (we) lost saw the deceased alive on <u>SEPT. 26</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. C. DiVamco, M.D.</u>			23B. DATE SIGNED <u>SEPT. 26, 1971</u>		
23C. PHYSICIAN'S NAME (Type) <u>A. C. DIVAMCO, M.D.</u>			23D. ADDRESS <u>SINAI HOSP. BALTIMORE</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-30-71</u>	24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Arbutus, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Scott Funeral Home 1129 N. Caroline</u>	

1974  
1975  
1976

11-1-77

1978

1979

1980

1981

1982

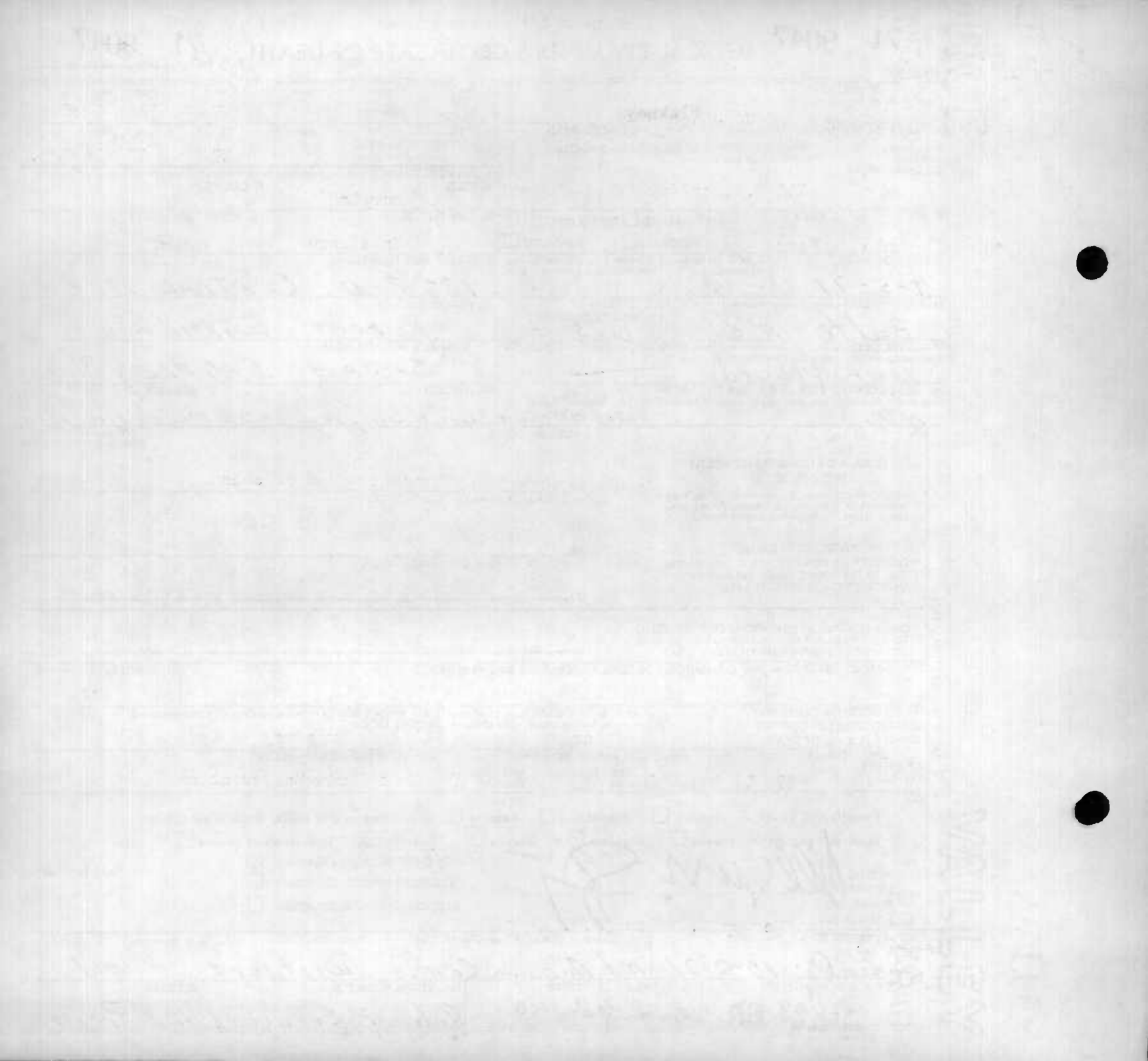
1983

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

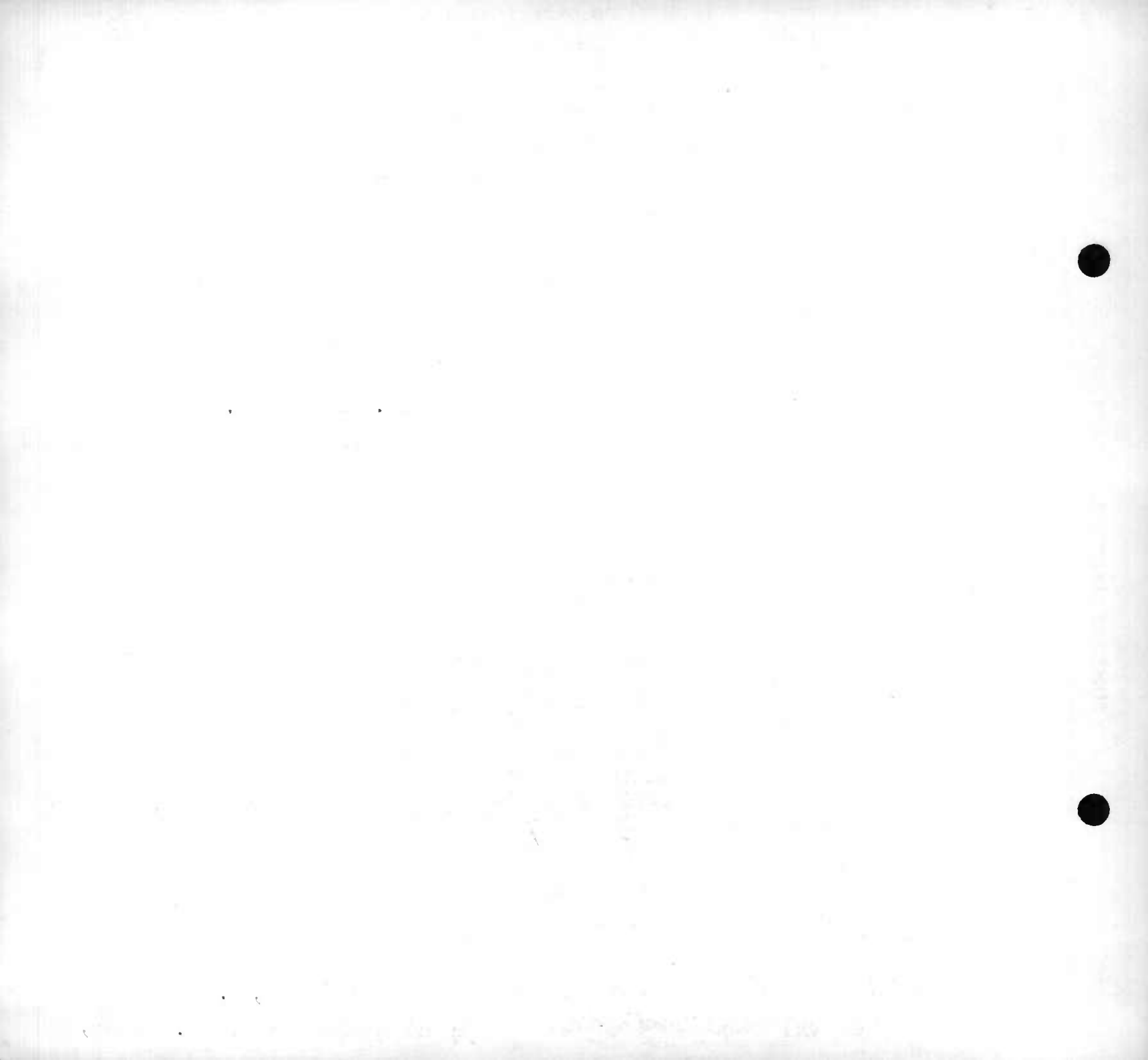
1. NAME OF DECEASED (Type or Print) <b>Jerome Blakney</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 27 Year 71 Hour 10:50 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>1442 N. Broadway</b>		3. DATE PRONOUNCED DEAD Month 9 Day 27 Year 71 Hour 10:50 P.M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>9-5-71</b>		10. AGE (In years lost birthday) <b>19?</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltd. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, near unknown) (If yes, give war or dates of service) <b>NO.</b>		17. SOCIAL SECURITY NO. <b>214-56-5016</b>	
18. INFORMANT <b>Sarah Shipley</b>		ADDRESS <b>1325 N. Central Ave.</b>	
19. CAUSE OF DEATH <b>E9651X</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Gunshot wound of chest DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Bar</b>	
22D. TIME OF INJURY (APPROX.) 9 27 71 10:50 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1442 N. Broadway</b>		22F. HOW DID INJURY OCCUR? <b>Shot during altercation</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) <b>Werner H. Spitz, M.D.</b>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-2-71</b>	
24C. NAME OF CEMETERY or CREMATORY <b>mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>West Port Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Talbot, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Guthrie B. Scruggs</b>		ADDRESS <b>1412 E. Preston St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>71 9048</b>	
BIRTH NO. <b>71 9048</b>		1. NAME OF DECEASED (Type or Print) <b>ANNE L. TIMANUS</b>		2. DATE AND HOUR OF DEATH <b>9-27-71, 2.21 PM.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME &amp; HOSPITAL, 35 BALTO. MD.</b>			A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>BALTIMORE CITY</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>9 W. Barney Street 21230</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-1-1895</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>MD. USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>
13. FATHER'S NAME <b>JACOB SCHNEIDER</b>			14. MOTHER'S MAIDEN NAME <b>KATHERINE ALBACH</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219 26 6051</b>	17. INFORMANT <b>Carroll E. Timanus 9 W. Barney Street</b>		
18. <b>569.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Cerebro-Resp. failure</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CEREBRAL STROKE, DEHYDRATION</b>		
			(B) <b>SMALL BOWEL FISTULA, ULCERATIVE COLITIS</b> DUE TO, OR AS A CONSEQUENCE OF: <b>17 days</b>		
			(C) <b>Perforated diverticulitis, com.</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>9-15-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>SMALL BOWEL FISTULA ULCERATIVE COLITIS</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NO</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>	
21D. TIME OF INJURY (APPROX.) 1 Month ( ) Day ( ) Year ( ) Hour ( ) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> - Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>8/22</b> 19 <b>71</b> to <b>9/27</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>9/27</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>E. Borhani M.D.</b>				23B. DATE SIGNED <b>9, 27, 71</b>	
23C. PHYSICIAN'S NAME (Type) <b>ENAYATOLLAH BORHANI</b> <b>AZAR</b>				23D. ADDRESS <b>CHURCH HOME &amp; HOSP.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/30/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State) <b>-</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>MA Coffey Funeral Home 130 E. Fort Ave,</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

71 9049

REG. NO.

71 9049

1. NAME OF DECEASED (Type or Print) <b>CHESTER KING</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 26 1971 2:40 p.m.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Arlington</b>	
9. DATE OF BIRTH <b>May 29, 1948</b>		10. AGE (In years lost birthday) <b>23</b>	
11. BIRTHPLACE (State or foreign country) <b>Texas</b>		12. CITIZEN OF <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Parts Salesman</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Automobile Company</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 8-2-65 9-20-68</b>		17. SOCIAL SECURITY NO. <b>456-82-8437</b>	
18. INFORMANT <b>Hanner Funeral Home</b>		ADDRESS <b>New Boston, Texas</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>E815.10</b>		CAUSE OF DEATH <b>Multiple injuries</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>highway</b>	
22D. TIME OF INJURY (APPROX.) <b>9-26-71</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Rt. 495</b>		22F. HOW DID INJURY OCCUR? <b>Driver of car that left roadway and struck pole.</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-30-71</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Ringwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>New Boston, Bowie, Texas</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Jaber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, Inc.</b>		ADDRESS <b>Towson, Md.</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9050</u>	
BIRTH NO. <u>71 9050</u>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>Rupert C. Cowles</b>		2. DATE AND HOUR OF DEATH <b>9/26/1971</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 2703 Mt. Holly St.</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>2703 Mt. Holly St.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/6/1881</b>	9. AGE (In years lost birthday) <b>90</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired suveyor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Marie</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Peter T. Cowles</b>		14. MOTHER'S MAIDEN NAME <b>Laura Hubbard</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-32-8869</b>		17. INFORMANT ADDRESS <b>Philip C. Cowles 3111 N. Charles St</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>205-91</b> I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>? cerebrovascular hemorrhage</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Myelogenous leukemia</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myelogenous leukemia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>None</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2 March</b> 19 <b>71</b> to <b>26 September</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>24 September</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Shaham Benecin M.D.</b>		23B. DATE SIGNED <b>27 September 71</b>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>611 Park Ave, Baltimore Md 21201</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/28/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cent.</b>	
24D. LOCATION <b>Woodlawn Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Mitchell Wiedefeld Home 6500 York Rd.</b>	

512-35-889

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

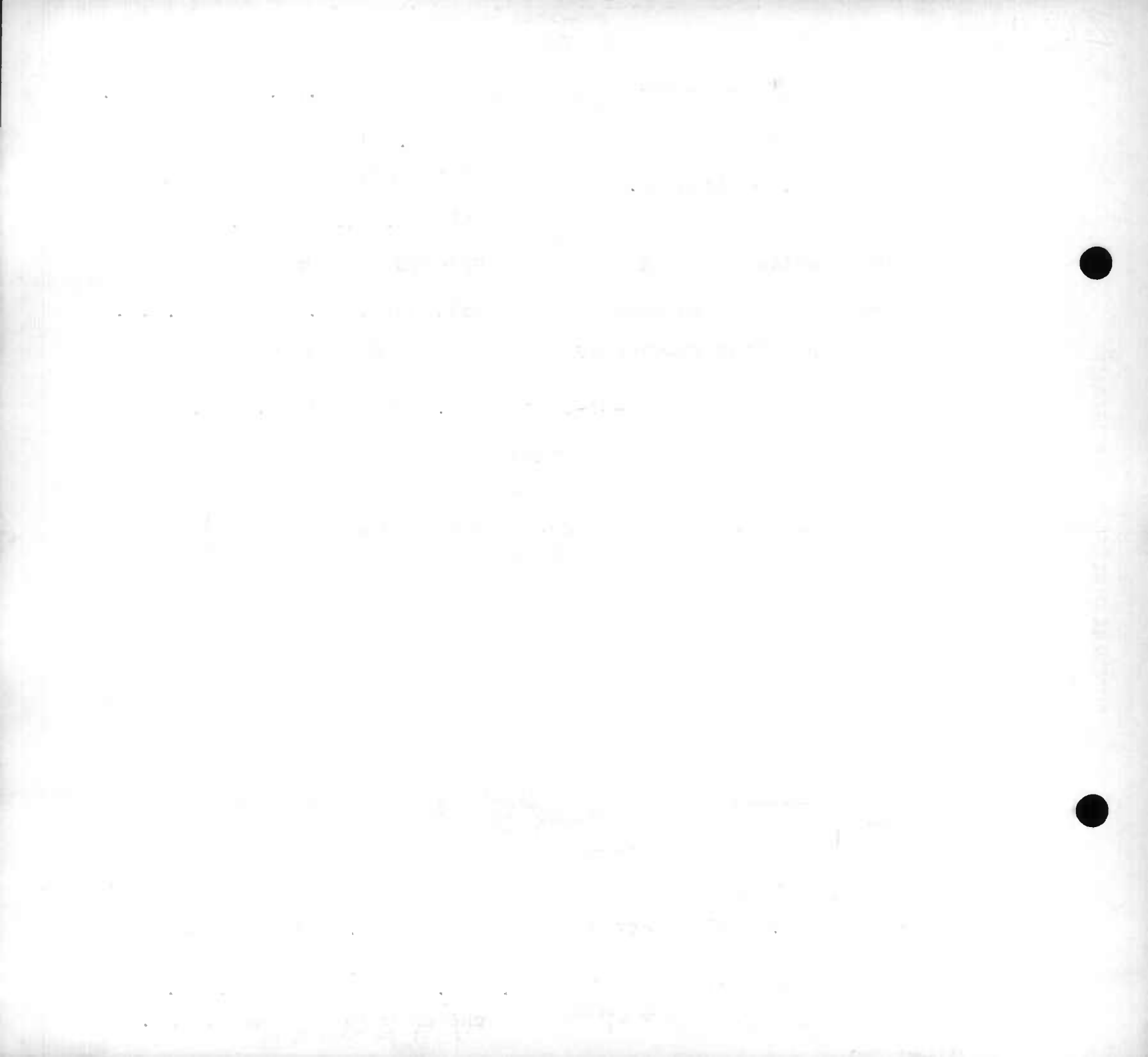
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 9051	
71 9051				BALTIMORE CITY HEALTH DEPARTMENT	
CERTIFICATE OF DEATH				REG. NO. 71 9051	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Finkel, Doka</i>	
2. DATE AND HOUR OF DEATH <i>Sept. 24 1971 6:30 A.M.</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>2831</i>				FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hosp</i>	
C. CITY OR TOWN <i>Balto</i>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>6610 Vincent Lane</i>				5. SEX <i>W</i> 6. RACE <i>F</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>April 17, 1890</i>				9. AGE (In years last birthday) <i>81</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>MD</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Morris</i>				14. MOTHER'S MAIDEN NAME <i>Rachael</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Hoop Clark</i>				ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>One hour.</i> <i>years.</i>	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>NO</i>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that <i>U</i> (this hospital) attended the deceased from <i>9-18-71</i> to <i>9-24-71</i> that <i>U</i> (we) last saw the deceased alive on <i>9-24-71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.				23A. SIGNATURE <i>Mansour</i>	
23B. DATE SIGNED <i>Sept 24 71</i>				23C. PHYSICIAN'S NAME (Typal)	
23D. ADDRESS				23E. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>9/26/71</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Chesek Cemetery</i>				24D. LOCATION (City, town, or county) (State) <i>Balto MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 29 1971</i>				25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Splawn &amp; Sons</i>				ADDRESS <i>9610 Reisterstown</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

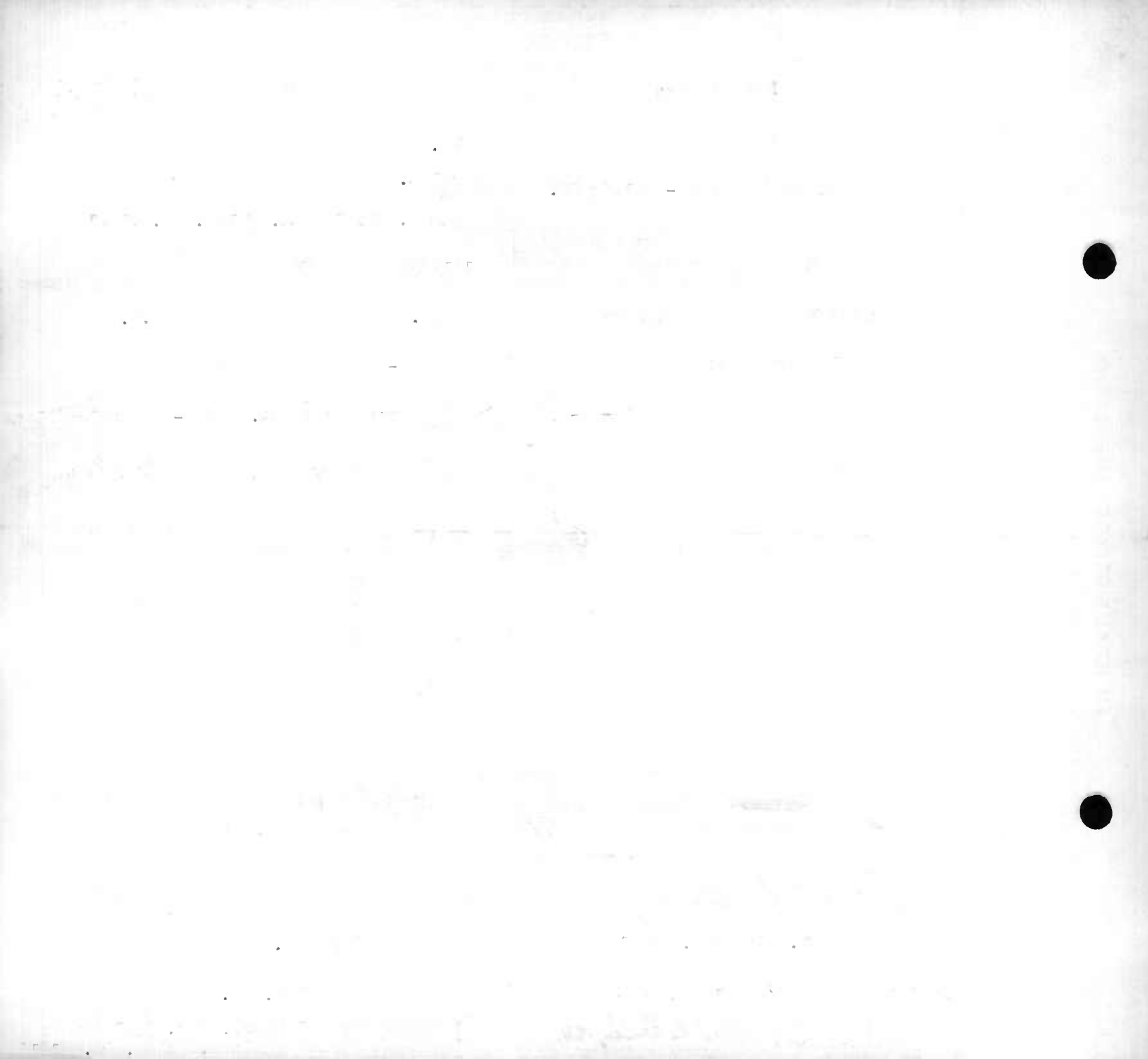
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9052</u>	
BIRTH NO. <u>71 9052</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MARIA ZARAS</b>		2. DATE AND HOUR OF DEATH <b>Sept. 24, 1971</b>   <b>5 a.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>00 2612 E. Madison St.</b>		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <b>Md. 21205</b> B. COUNTY <b>702</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2612 E. Madison St.</b>			
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/16/75</b>	9. AGE (In years last birthday) <b>96</b>	10. Under 1 Yr. Months: Days:   11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Wenceslaus Velenovsky</b>		14. MOTHER'S MAIDEN NAME <b>Mary Beran</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>199-03-3315D</b>		17. INFORMANT ADDRESS <b>Mrs. Frieda Jirsa, dght, above</b>	
18. <b>431.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebrovascular Hemorrhage</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerosis</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerosis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>June 15</u> 19 <u>71</u> to <u>September 24</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>September 16</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.			
23A. SIGNATURE <i>Melito M. Torres, M.D.</i>		23B. DATE SIGNED <u>Sept 25, 1971</u>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Melito Torres</b>	
23D. ADDRESS <b>441 S. Ellwood Avenue</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>9/27/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Bohemian Nat. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1971</b>		25B. NAME OF REGULAR FUNERAL HOME <b>Robert E. Schimunek</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 8331 Brecht Lane</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9053</u>	
BIRTH NO. <u>71 9053</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Louise Bosz</u>			2. DATE AND HOUR OF DEATH <u>9/26/71</u> <u>7:30 A.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 House in Pines - Belair Rd.</u>			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1102</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>524 N. Charles St. Balto. Md. 21201</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/17/92</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>Charles Krummeck</u>			14. MOTHER'S MAIDEN NAME <u>-</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-05-4759</u>		17. INFORMANT <u>Henry Bosz (son)</u> ADDRESS <u>Apt. 2003 - 8 Charles Plaza</u>	
18. <u>412.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Anterior wall Myocardial Infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Congestive Heart Failure, Chronic Brain Disease</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Anterior wall Myocardial Infarction</u> (B) <u>Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>-</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>&gt; 2 1/2 yrs</u> <u>" "</u> <u>" "</u>
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <u>3/11/1969</u> to <u>9/26/1971</u> that (I) ( <del>we</del> ) last saw the deceased alive on <u>9/22/1971</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>the hospital</del> ) (did not) view the body after death.					
23A. SIGNATURE <u>Albert B. Bradley</u> DEGREE				23B. DATE SIGNED <u>9/27/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Albert B. Bradley</u> DEGREE				23D. ADDRESS <u>4900 Belair Rd.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/28/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Glen Haven Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Balto. Md.</u>		(State)			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 29 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Schimmek Funeral Homes, Inc.</u> ADDRESS <u>3331 Brehms Lane, Balto. Md. 21223</u>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9054</u>
BIRTH NO. <u>71 9054</u>		1. NAME OF DECEASED (Type or Print) <u>Victoria Gladys Epps</u>		
2. DATE AND HOUR OF DEATH <u>9/27/71</u> <u>3:00</u> a. m.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u>		A. STATE <u>MD</u> B. COUNTY <u>802</u>		
5. SEX <u>F</u>		6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>05-04-07</u>		9. AGE (In years last birthday) <u>64</u>		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Dragonville, Va.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>George Williams</u>		
14. MOTHER'S MAIDEN NAME <u>Nixon Martha Borne</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>215-32-1013</u>		17. INFORMANT <u>Helen C. Chase, 605 Dembytown Road, Joppa, Md.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic Renal Failure</u> (B) <u>Congestive Heart Failure</u> (C) <u>Severe edema</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>3 weeks</u> <u>3 weeks</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Peritonitis</u>		<u>6 days</u>		
19A. DATE OF OPERATION <u>9/20</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>0</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>0</u>		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>9/9</u> 19 <u>71</u> to <u>9/27</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/27</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did</u> (did not) view the body after death.				
23A. SIGNATURE <u>W. Michael Tucker M.D.</u>		23B. DATE SIGNED <u>9/27</u>		23C. PHYSICIAN'S NAME (Type) <u>W. Michael Tucker M.D.</u>
23D. ADDRESS <u>Box 83</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>Sept. 30, 1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Community Baptist Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Joppa Harford Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 29 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Howard K. McComas, III</u>
				ADDRESS <u>Abingdon, Md.</u>

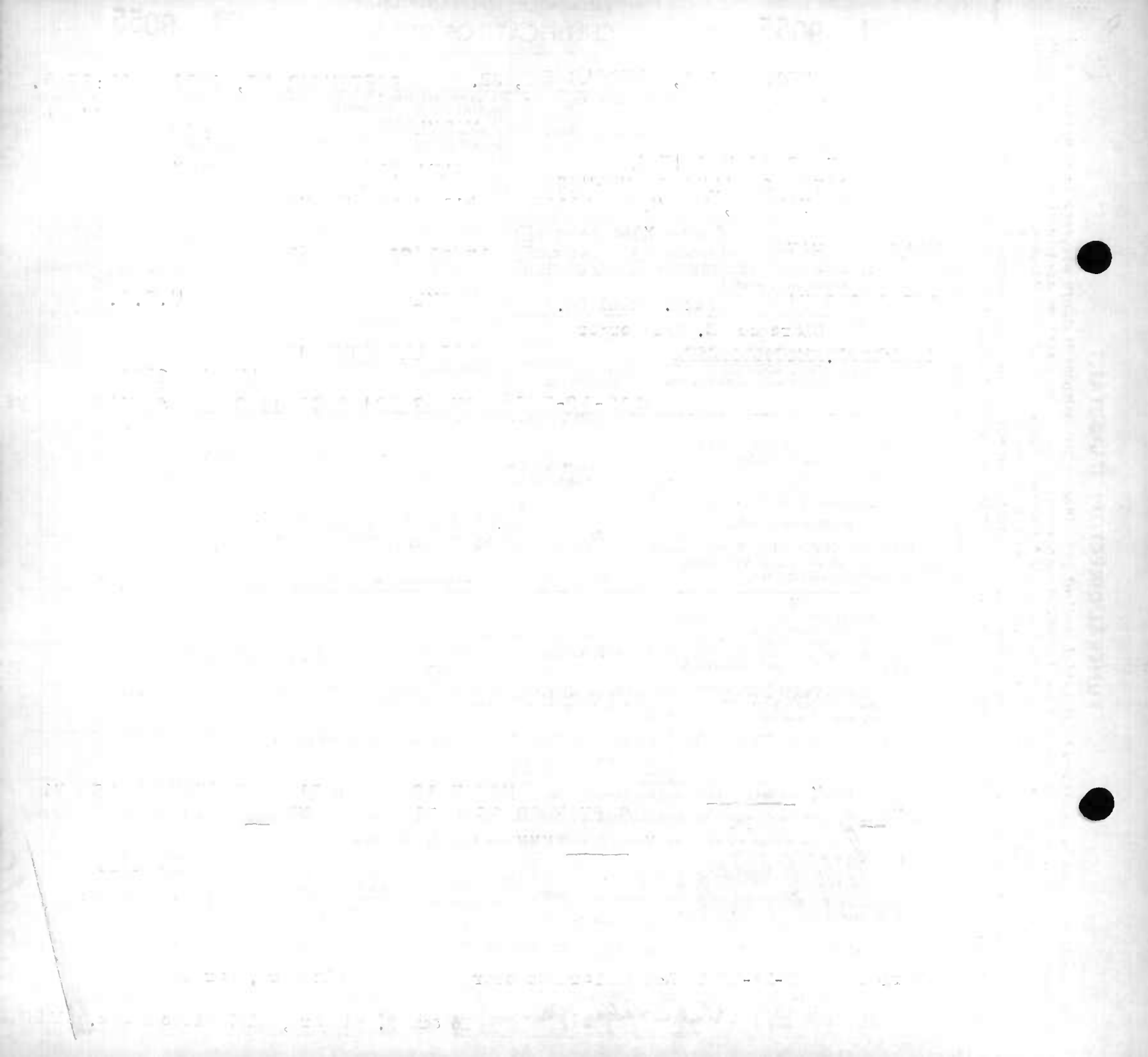
17/10/71

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 71 9055

BIRTH NO. 71 9055		2. DATE AND HOUR OF DEATH SEPTEMBER 25, 1971 12:35 A.M.	
1. NAME OF DECEASED (Type or Print) HORNBERGER, EMERALD E, SR.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-41	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 417 YALE AVENUE	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/27/03
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REFRIERATION		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	9. AGE (In years last birthday) 67
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence E. Hornberger		14. MOTHER'S MAIDEN NAME ROSELLA EDWARDS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-10-7858	
17. (INFORMANT BALTO MD 21229 ST AGNES' RECORDS CATON & WILKENS AVE.		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Respiratory Failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of larynx (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II			
19A. DATE OF OPERATION NO		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) 21D. TIME OF INJURY (APPROX) V		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from AUGUST 10 19 71 to SEPTEMBER 25 19 71 that (X) (we) last saw the deceased alive on SEPTEMBER 25 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (view) the body after death.			
23A. SIGNATURE R. E. Gurest		23B. DATE SIGNED 9/25/71	
23C. PHYSICIAN'S NAME (Type) R. E. Gurest		23D. ADDRESS ST AGNES HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-28-1971	
24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 29 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard		25D. ADDRESS 4107 Wilkens Ave. 21229	



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71 9056

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 9056  
REG. NO.

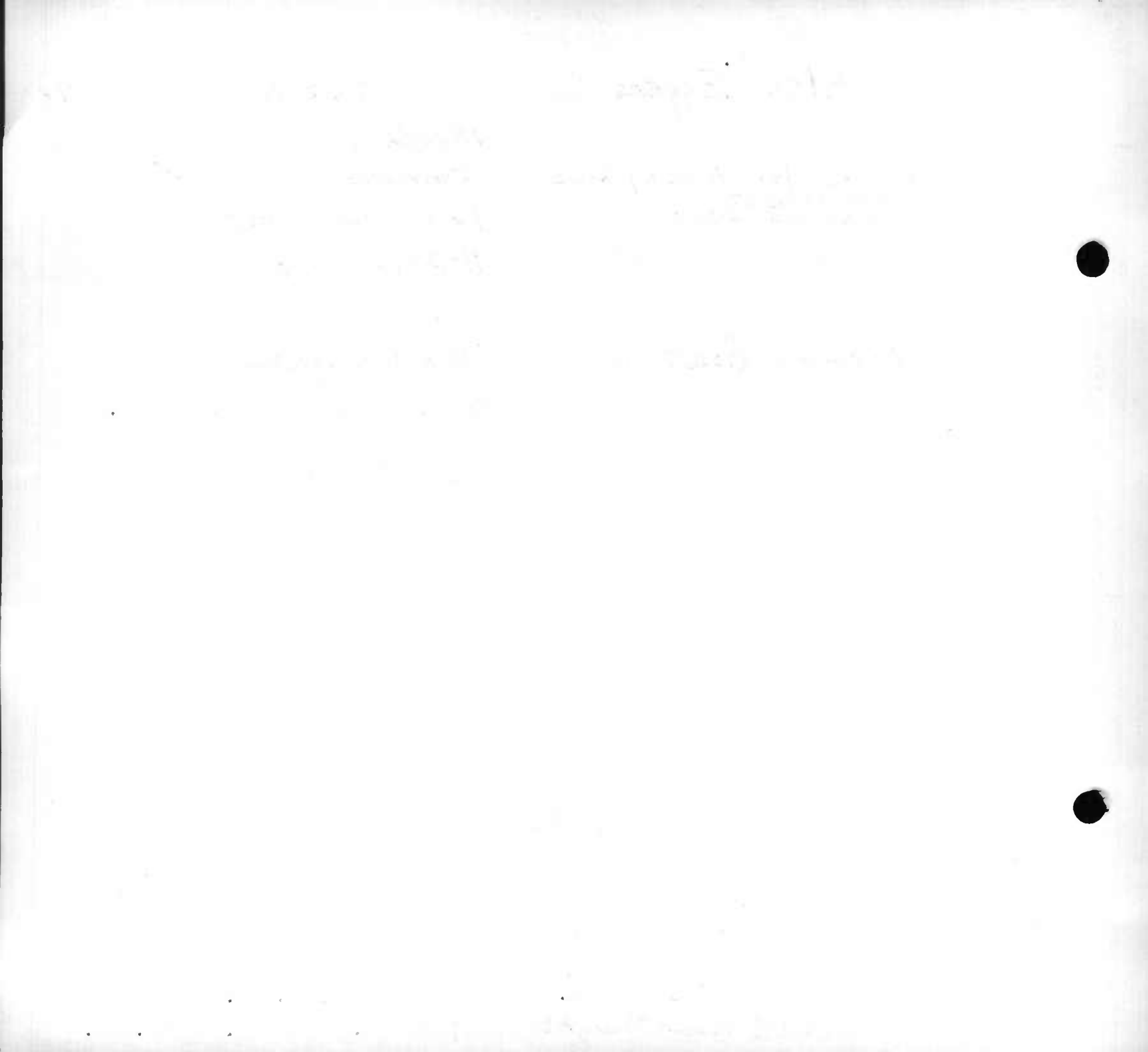
BIRTH NO.

1. NAME OF DECEASED (Type or Print) James Scott		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year 9 26 71 Hour 12:30 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year 9 26 71 Hour 12:30 a.m.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Nov-11-1932		10. AGE (In years last birthday) 38	
11. BIRTHPLACE (State or foreign country) Balto MD		12. CITIZEN OF USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRONIC REPAIRMAN		15. MOTHER'S MAIDEN NAME TWOOTY McDONALD	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) WWII		17. SOCIAL SECURITY NO.	
18. INFORMANT 20186 Scott 3030 HANZON AVE		ADDRESS	
19. 303.91 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute Alcoholic Intoxication ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 21		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) yes	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) PETER LIPKOVIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/26/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/26/71	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. SEP 29 1971		25B. NAME OF REGISTRAR Valerie E. Fisher, R.D.	
25C. FUNERAL DIRECTOR Maurice P. Lange		ADDRESS 6887 Gibson	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.5em;">71 9057</span>
BIRTH NO. <span style="font-size: 1.5em;">2621</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.5em;">9-26-71 7 PM</span>		
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.5em;">Elsie Eggers</span>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">Bolton Hill Nursing Home</span>		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <span style="font-size: 1.5em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">907</span>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">1400 John St. Balto. Md. 21217</span>		C. CITY OR TOWN <span style="font-size: 1.5em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <span style="font-size: 1.5em;">1629 Gopsuch Ave</span>				
5. SEX <span style="font-size: 1.5em;">F</span>	6. RACE <span style="font-size: 1.5em;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.5em;">11-2-86</span>	9. AGE (in years last birthday) <span style="font-size: 1.5em;">84</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">Md.</span>
12. CITIZEN OF WHAT COUNTRY <span style="font-size: 1.5em;">USA</span>				
13. FATHER'S NAME <span style="font-size: 1.5em;">Theodore Borst</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">Eliza Mary Wagner</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">no</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.5em;">none</span>		17. INFORMANT ADDRESS <span style="font-size: 1.5em;">Bernard Morris 6108 Parkway Dr.</span>
18. <span style="font-size: 1.5em;">7/12/201</span>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <span style="font-size: 1.5em;">Hypertensive C.V. disease</span> DUE TO, OR AS A CONSEQUENCE OF:  (B) <span style="font-size: 1.5em;">arteriosclerosis</span> DUE TO, OR AS A CONSEQUENCE OF:  (C) <span style="font-size: 1.5em;">cerebral</span>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">years</span>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">1/25</span> 1968 to <span style="font-size: 1.5em;">9/26</span> 1971 that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">9/26</span> 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <span style="font-size: 1.5em;">[Signature]</span>		23B. DATE SIGNED <span style="font-size: 1.5em;">9/27/71</span>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">ALAN H. MACHT MD</span>		23D. ADDRESS <span style="font-size: 1.5em;">215 Paul St Balto Md</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">Burial</span>		24B. DATE <span style="font-size: 1.5em;">9/29/71</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.5em;">Loudon Pk.</span>
24D. LOCATION (City, town, or county) <span style="font-size: 1.5em;">Balto. Md.</span>		24E. (State)		
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">SEP 29 1971</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Taylor, MD</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">Leonard J. Ruck Inc. Balto. Md.</span>





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 9058</b>
BIRTH NO. <b>71 9058</b>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>Pipitone, Isabella P.</b>		2. DATE AND HOUR OF DEATH <b>9-27-71 6<sup>00</sup> Pm M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>South Baltimore General Hosp.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>43</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>12-21-82</b>
13. FATHER'S NAME <b>Joseph Pelligrino</b>		14. MOTHER'S MAIDEN NAME <b>Antoinette ?</b>		9. AGE (in years last birthday) <b>88</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-48-58824</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>
17. INFORMANT <b>Miss Grace Pipitone</b>		ADDRESS <b>Same</b>		
18. <b>131.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Poss. Subdural hemorrhage</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Poss. C.V.A.</b> (C) <b>Poss. C.V.A.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 27, 2AM 1971</b> to <b>Sept. 27, 6PM 1971</b> that (I) (we) last saw the deceased alive on <b>Sept 27 1971</b> and that (n(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Geo. J. Noh</b>		23B. DATE SIGNED <b>Sept 29/71</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>Leonard J. Buck Inc. Baltimore, Md</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/30/71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>
24D. LOCATION <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1971</b>		
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Buck Inc. Baltimore, Md</b>		



Released on: Approved: *W-623*

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. **71 9059**

BIRTH NO. <b>71 9059</b>		1. NAME OF DECEASED <b>MR OTIS B. WRIGHT</b> (Type or Print) <b>FRACTURE RT HIP &amp; Myocardial Ischemia</b>		2. DATE AND HOUR OF DEATH <b>9/27/71 4:15 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b> <b>44</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>ANNAPOLIS</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>213 W. 29TH STREET</b>		
5. SEX <b>MALE</b>	6. RACE <b>AMERICAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>09/08/98</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Stationary</b> <del>Supermarket</del> <b>Eng.</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
13. FATHER'S NAME <b>WOODY WRIGHT</b>			14. MOTHER'S MAIDEN NAME <b>ANNIE MAYS</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>227-03-4207</b>		17. INFORMANT <b>Mrs Ethel Wright</b> ADDRESS <b>Same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>HEART FAILURE</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>? Pneumonia</b> <b>Fr (C) Hip</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>9/20/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fr (C) Hip</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY i.e., in or about home, farm, factory, street, office bldg, etc.) <b>Home (C)</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>above address 1207</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx) <b>9/20/71</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fall at home</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>9/20</b> 19 <b>71</b> to <b>9/27</b> 19 <b>71</b> and that (I) (we) last saw the deceased alive on <b>9/27</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>V. Virendra</b>			23B. DATE SIGNED <b>9/27/71</b>		23C. PHYSICIAN'S NAME (Type) <b>VIRA VISHESHSINDH</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>9/30/71</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1971</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard E. Ruck Inc. Baltimore, Md</b>

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 9060</b>	
71 9060		<b>CERTIFICATE OF DEATH</b>			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Alestia C. Scofield</b>		2. DATE AND HOUR OF DEATH <b>9/26/71</b> <b>12:40</b> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>CAROLINE</b>		5. CITY OR TOWN <b>DENTON</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>1009 GAY STREET</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>01-26-60</b>	9. AGE (In years last birthday) <b>11</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT (school)</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>EASTON, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		13. FATHER'S NAME <b>ROGER SCOFIELD</b>		14. MOTHER'S MAIDEN NAME <b>CONSOLA WALKER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Roger Scofield (father) same as above</b>	
18. <b>116.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Brain</b> <b>Acute Hemorrhage</b> <b>Cardio-respiratory arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cryptococcal Meningitis</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mins</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-1</b> 19 <b>71</b> to <b>9-26</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>9-26</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Marie McCormick M.D.</b>		23B. DATE SIGNED <b>9/26/71</b>		23C. PHYSICIAN'S NAME (Type) <b>MARIE MCCORMICK M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/29/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Springgrove cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Denton, Caroline, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>	
25C. FUNERAL DIRECTOR <b>CHARLES W. HILL</b>		25D. ADDRESS <b>DENTON, MARYLAND</b>			

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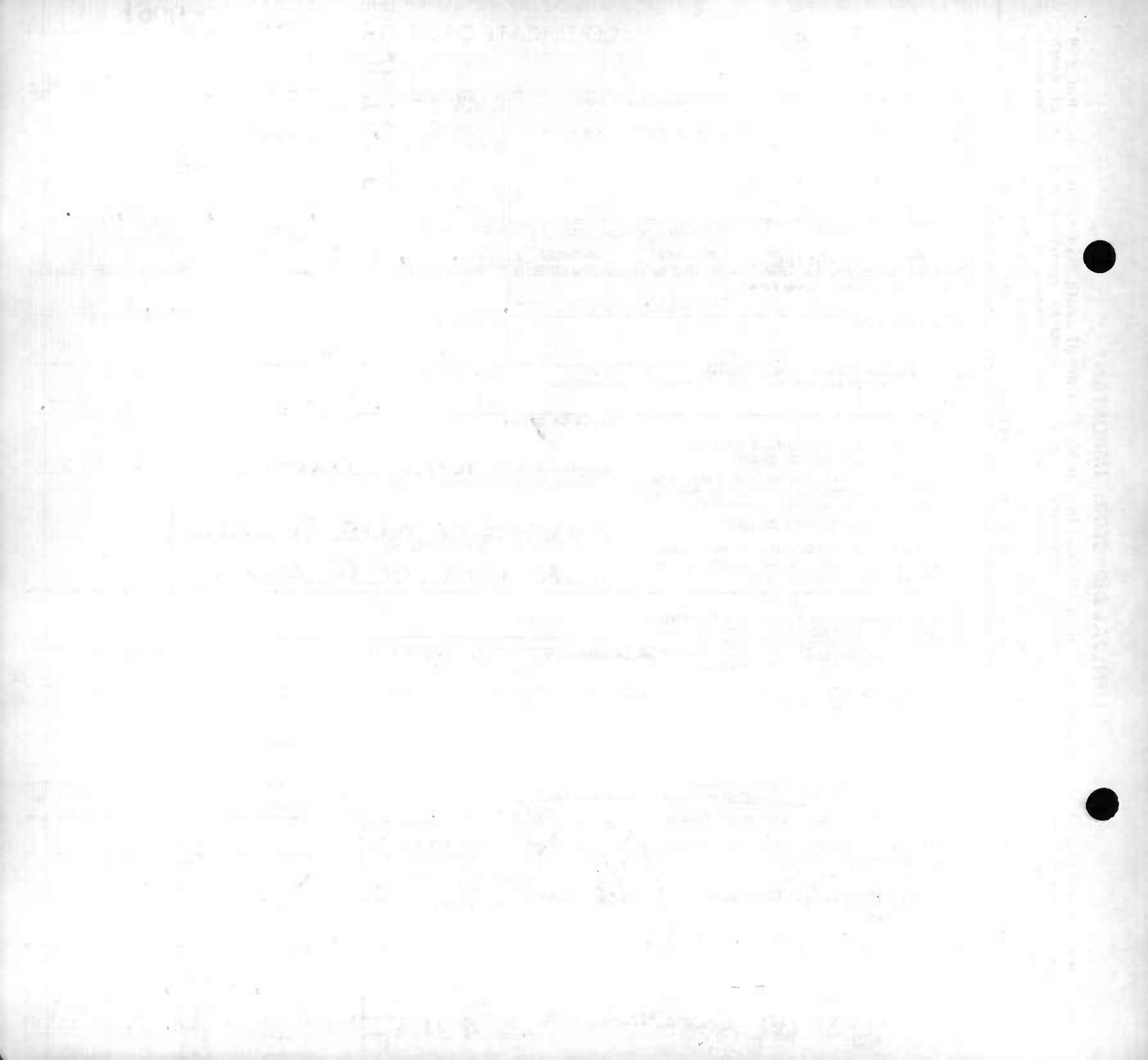
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10-1-1919

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 9061	
BIRTH NO. 71 9061				2. DATE AND HOUR OF DEATH 9/27/71 2:15 A.M.			
1. NAME OF DECEASED (Type or Print) Eva Parker				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland, Baltimore 5300			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 37 Mercy Hospital				C. CITY OR TOWN Rosedale		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5705 Hamilton, Avenue, Balto, Md.		21237	
5. SEX F	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 19, 1916	9. AGE (In years last birthday) 55	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Duvalls Paking Co.				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Edward Lewandowski				14. MOTHER'S MAIDEN NAME Mary Harnek			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS William V. Parker 5705 Hamilton Ave.	
18. 174X I CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE HE PATIC FAILURE DUE TO, OR AS A CONSEQUENCE OF:		2 WKS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) METASTATIC CA BREAST TO LIVER DUE TO, OR AS A CONSEQUENCE OF:		?	
				(C) CARCINOMA OF C BREAST		?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Inotily medical examined <input type="checkbox"/>		21B. PLACE OF INJURY i.e., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 9/27 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Thomas S. Brumora MD				23B. DATE SIGNED 9/27/71		23C. PHYSICIAN'S NAME (Type) Thomas S. Brumora MD	
23D. ADDRESS Mercy Hospital Staff							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-1-71		24C. NAME of CEMETERY or CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) Dundalk, Balto, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 24 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John M. Weber & Sons Inc.		ADDRESS 401 S. Chester	

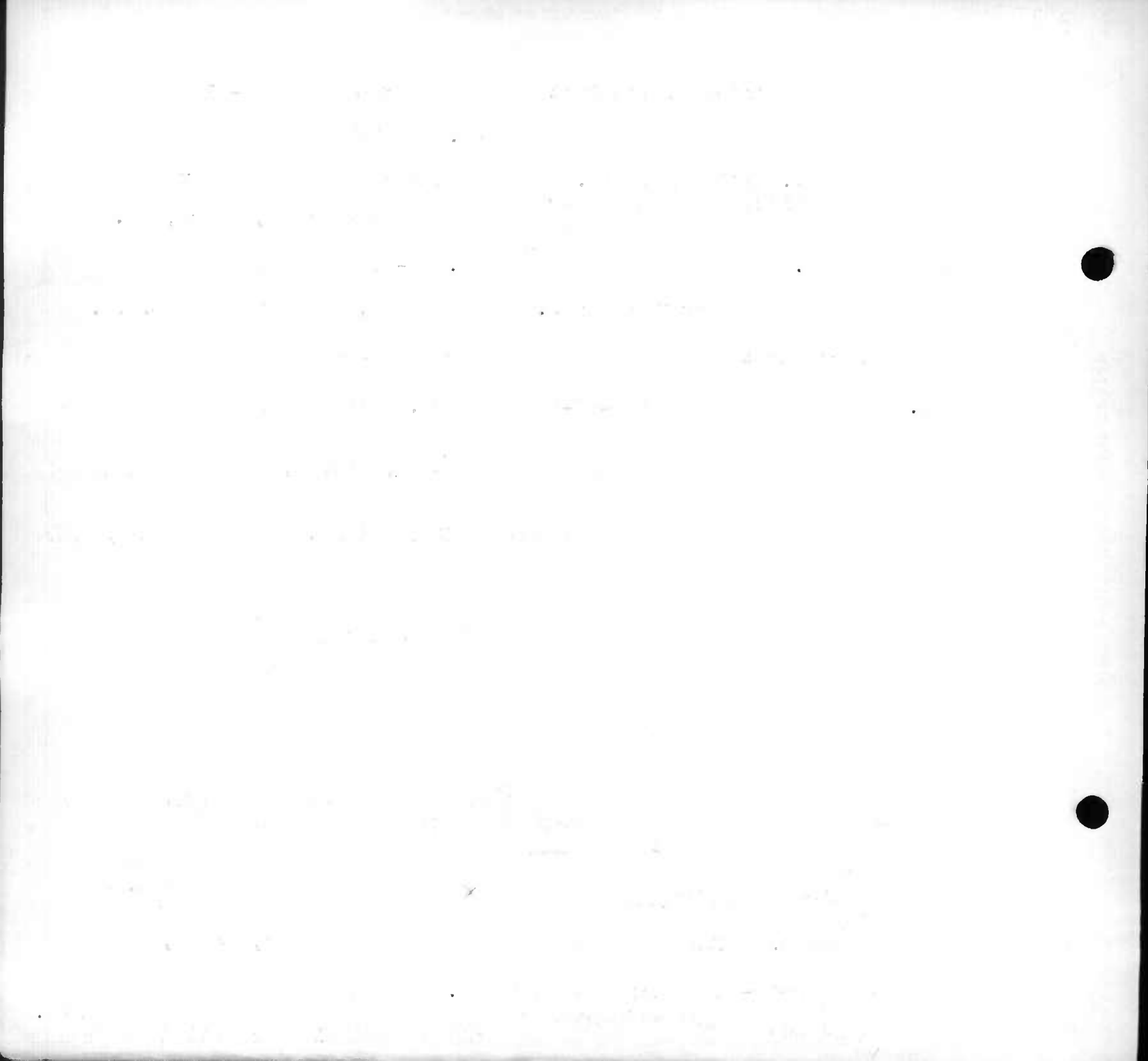




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

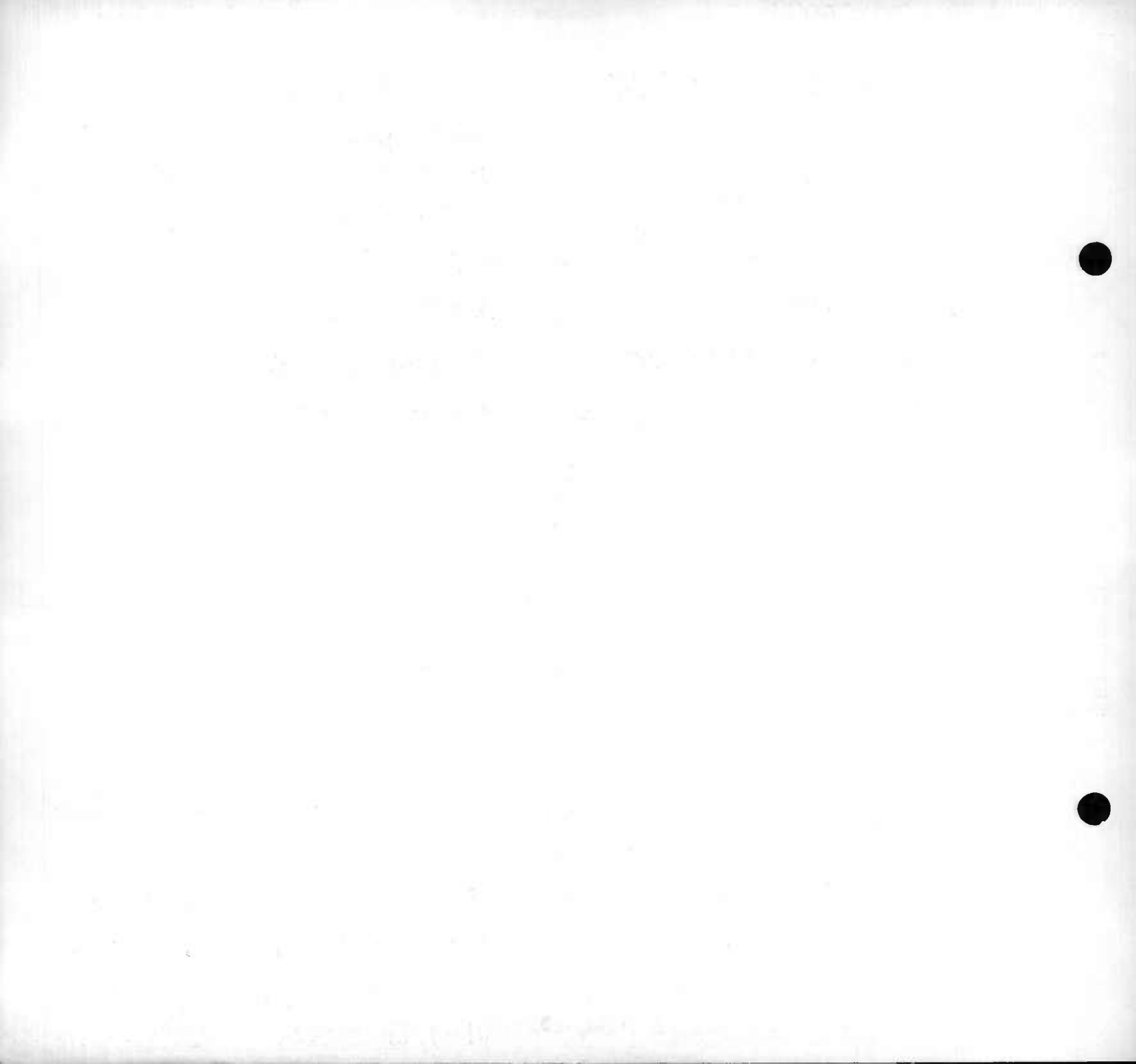
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9062</u>	
BIRTH NO. <u>71 9062</u>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>William A. Potthast</u>			2. DATE AND HOUR OF DEATH <u>September 24-71</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> <u>2854</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> <u>11. Mallow Hill Rd.</u> <u>Balto, Maryland 21239</u>			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <u>11 Mallow Hill Rd, Balto, Md.</u>		
5. SEX <u>Male</u>	6. RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18-02</u>	9. AGE (In years last birthday) <u>68yrs</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind at work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Potthast Bros.</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>John A. Potthast</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Lieb</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>215-05-1926A</u>	17. INFORMANT ADDRESS <u>Mrs. Griffin 5310 WENPLEY RD</u>		
18. <u>410.9</u> I CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Arrest</u> <u>Second</u>		
			(B) <u>Cerebral thrombosis</u> <u>minutes</u>		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<u>Status, post myocardial infarction</u> <u>9/7</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> <u>19 57</u> to <u>9/24</u> <u>19 71</u> that (I) (we) last saw the deceased alive on <u>9/23</u> <u>19 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James J. Nolan</u>			23B. DATE SIGNED <u>9/24/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>Jas J. Nolan</u> MD			23D. ADDRESS <u>1 Mallow Hill Road, Balto, Maryland</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9-27-71</u>	24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 29 1971</u>	25B. NAME OF REGISTRAR <u>James J. Nolan</u>	25C. FUNERAL DIRECTOR ADDRESS <u>Heber Funeral Home 5311 Edmondson Ave.</u>			



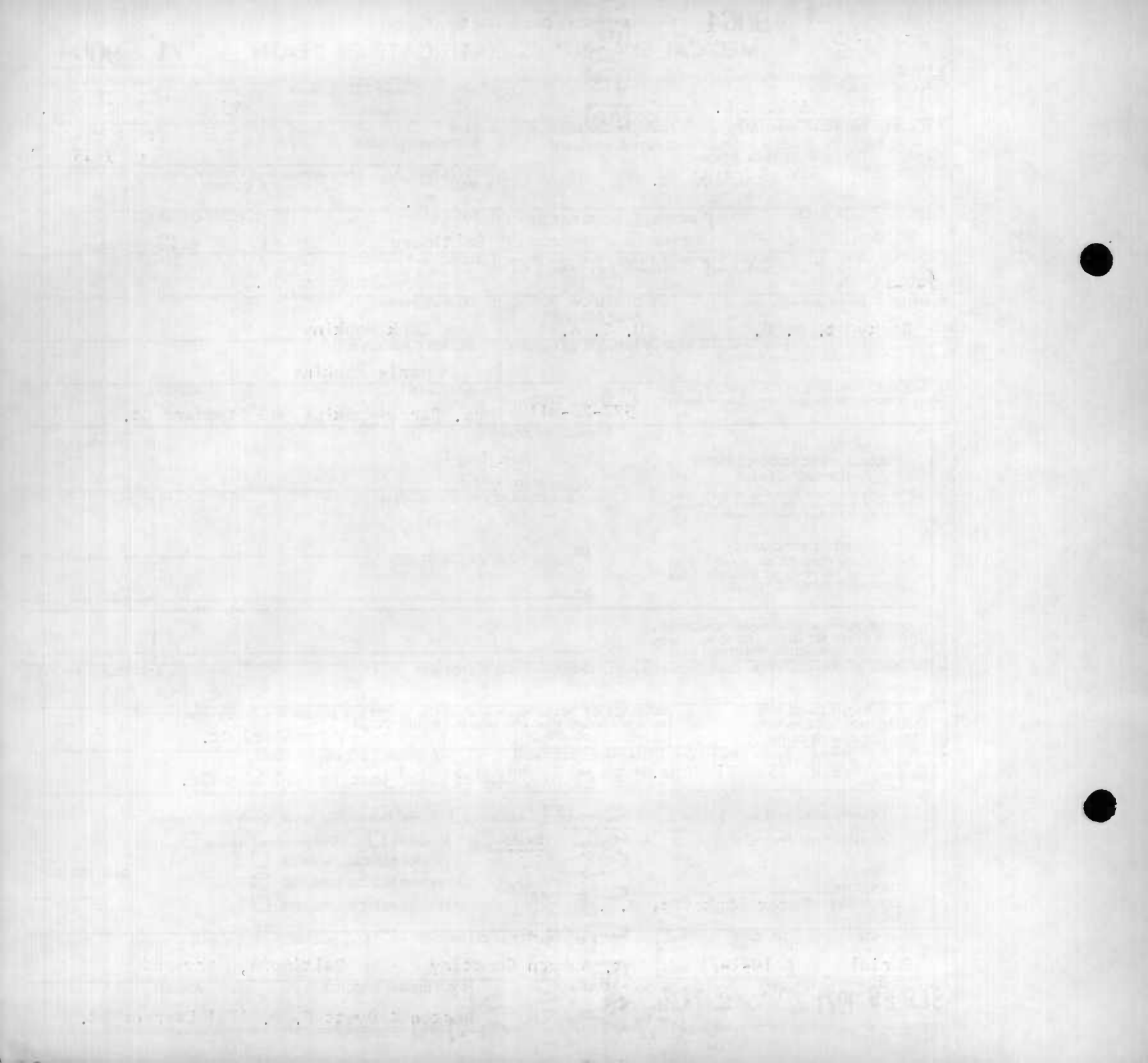
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

71 9063		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9063	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>ROSE SPINE</u>			
2. DATE AND HOUR OF DEATH <u>9-27-1971</u> <u>6<sup>00</sup></u> P. M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>305 S. HIGH ST.</u>			
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>302</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>305 S. HIGH ST.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-1-1894</u>	9. AGE (In years last birthday) <u>77</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>SALVATORE MARINO</u>		14. MOTHER'S MAIDEN NAME <u>JOSEPHINE BUTTA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-40-8826</u>		17. INFORMANT <u>ANTHONY SPINE 305 S. HIGH ST.</u> ADDRESS	
18. <u>197.2</u> I		CAUSE OF DEATH <u>cord. Malignancy of spine</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>9/20</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>March</u> 19 <u>71</u> to <u>9/27</u> 19 <u>71</u> that (1) (we) lost saw the deceased alive on <u>9/20</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph R. Liberto MD</u>		23B. DATE SIGNED <u>9/29/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Joseph R. Liberto MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10-1-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>HOLY REDEEMER</u>	
24D. LOCATION (City, town, or county) <u>BALTIMORE</u>		24E. STATE <u>MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 29 1971</u>	
25B. NAME OF REGISTRAR <u>Robert E. Liberto MD</u>		25C. FUNERAL DIRECTOR <u>W. H. MANEBER &amp; SONS, INC.</u>		25D. ADDRESS <u>401 S. CHESTER ST</u>	



BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) William L. Hopkins		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 25 Year 71 Hour 2:35 p. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 964 Stoddard Ct.		3. DATE PRONOUNCED DEAD Month 9 Day 25 Year 71 Hour 2:35 p. M.	
6. SEX male		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1702	
7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 2-4-23	10. AGE (In years lost birthday) 48	E. STREET AND NUMBER 964 Stoddard Ct.	
11. BIRTHPLACE (State or foreign country) Rocky Mt. N. C.	12. CITIZEN OF WHAT COUNTRY? U. S. A.	13. FATHER'S NAME Zack Hopkins	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME Marie Hopkins	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	17. SOCIAL SECURITY NO. 577-28-4118	18. INFORMANT Mrs. Parry Hopkins 946 Stoddard Ct.	
19. E953X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Hanging (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) NO	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 964 Stoddard Ct. 1702	
22D. TIME OF INJURY (APPROX.) 9 25 71	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	22F. HOW DID INJURY OCCUR? Subject hanged himself.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9/26/71 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 10-1-71	24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. SEP 29 1971	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR ADDRESS Horton & Dyett F. H. 1701 Laurens St.	



1. NAME OF DECEASED (Type or Print) <b>CHRISTINE BENNETT</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2828 Westwood Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 26 1971 9:45 p.m.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1506</b>			
6. SEX <b>female</b>	7. RACE <b>negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>2-4-44</b>		10. AGE (in years last birthday) <b>27</b>	
11. BIRTHPLACE (State or foreign country) <b>Sumter, S. C.</b>		12. CITIZEN OF <b>U. S. A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nursing Home</b>		15. MOTHER'S MAIDEN NAME <b>Polly Bennett</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>218-44-5552</b>	
18. INFORMANT <b>Ross &amp; Robert Bennett</b>		ADDRESS <b>Paterson, N. J. 290 Van Houten</b>	
19. <b>011.7</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Massive pulmonary tuberculosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9-27-71</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>9-30-71</b>	24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1971</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Morton &amp; Dyett F. H. 1701 Laurens St.</b>	

VALLEY PAPERS CO.

PAY CONTINUITY

ALCANTARA & COMPANY



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

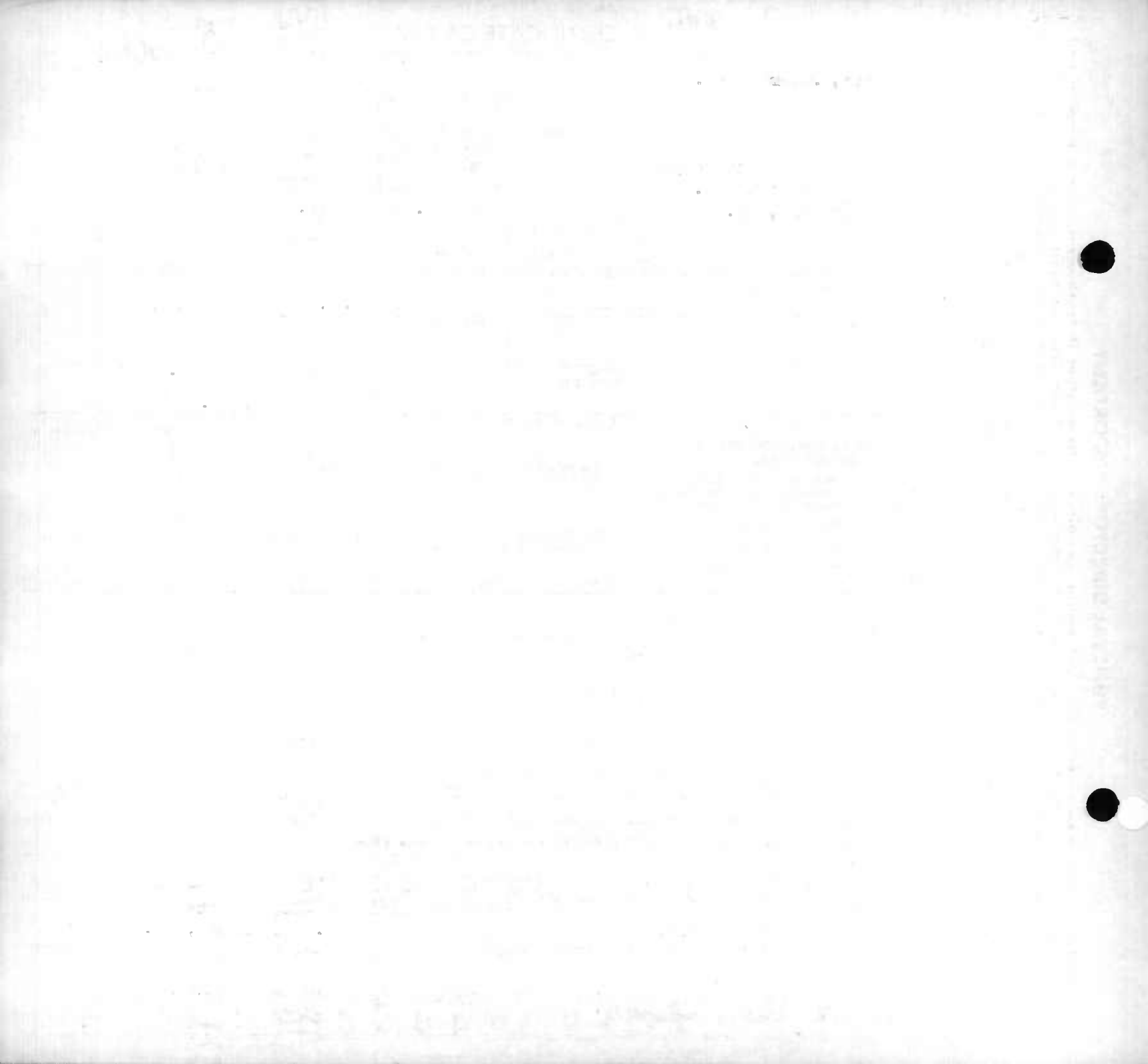
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9066</u>	
4-420 71 9066				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HOLLIS, Gwendolyn		Sept. 28, 1971 12:30 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u>			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY <u>1503</u>		
The Johns Hopkins Hospital			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1603 N. Bentalou Street		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Female	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11/8/33	37	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
			Raleigh Clothing Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Charles Roberts			Rae Hollis		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		214-32-1224		Rae Watts 1603 Bentalou St.	
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					0-15 minutes
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Pulmonary Edema</u>					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
<u>Alcoholism, Hepatic Cirrhosis</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
1				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from <u>Sept 27</u> 19 <u>71</u> to <u>Sept 28</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Sept 28: 12:30 am</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<u>Oleg Zimmerman M.D.</u>				9/28/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Oleg Zimmerman, M.D.				The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/28/10-2-71		Chesterfield Cem.	
				Queens Anne Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 29 1971		Robert E. Taylor, M.D.		V. Bailey	
				ADDRESS Kelson F.H. 1348 Calhoun St.	

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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 596068	
BIRTH NO. 5-524		31 9067		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Jones, Silas		2. DATE AND HOUR OF DEATH 9-26-71 2:30 AM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1933 W. North Ave. 21217					
5. SEX Male	6. RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-25-04	9. AGE (in years last birthday) 66	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Pitt Co., N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Cora Harris			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT 4940 Eastern Ave. ADDRESS BCH Records: Baltimore, Md. 21224	
18. 225.0 + 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction respiratory arrest. (B) Myocardial Infarction (Anterior), Diabetic. DUE TO, OR AS A CONSEQUENCE OF: (C) Cardiac insufficiency.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 9-16-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain Tumor		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-17 19 71 to 8-26 19 71 that (I) (we) last saw the deceased alive on 9-25-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hamid M.D.		23B. DATE SIGNED 9-26-71		23C. PHYSICIAN'S NAME (Type) Hamid M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-2-71		24C. NAME OF CEMETERY OR CREMATORY Church Cemetery	
24D. LOCATION Greenville, N.C.		24E. ADDRESS 4940 Eastern Ave. Baltimore, Md. 21224		24F. ADDRESS 1348 N. Calhoun St.	
25A. DATE RECD BY HEALTH DEPT. SEP 29 1971		25B. NAME OF REGISTRAR Kelson B. H.		25C. FUNERAL DIRECTOR Vernon R. Bailey	



BALTIMORE CITY HEALTH DEPARTMENT				71 9068
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. _____
1. NAME OF DECEASED (Type or Print) <b>Hezekiah GARDNER</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> _____ M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1115 Winchester Street</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 22, 1971 4:05 P.</b> M.
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1601</b>				
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>1-24-04</b>		10. AGE (In years lost birthday) <b>67</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		E. STREET AND NUMBER <b>1115 Winchester Street</b>
13. FATHER'S NAME <b>Hezekiah Gardner</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
15. MOTHER'S MAIDEN NAME <b>Mattie Holmes</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Miriam &amp; Ruth Gardner 7375 Furnace Br.</b>		
19. <b>412.4</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Arteriosclerotic cardiovascular disease  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> M.D. EXAMINER'S NAME (Type)  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>9/23/71</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-29-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REG'D BY HEALTH DEPT. <b>SEP 29 1971</b>		
25B. NAME OF REGISTRAR <b>Robert E. Bailey, Jr.</b>		25C. FUNERAL DIRECTOR <b>Kelson F.H. 1348 Calhoun Street</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9069</span>	
A-165				71 9069	
1. NAME OF DECEASED (Type or Print) <b>PEARL ABRAMS</b>			2. DATE AND HOUR OF DEATH <b>September 28, 1971 9:15 A. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>91 LEVINDALE</b>			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2717</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>Belvedere &amp; Greenspring Ave</b>		
5. SEX <b>Female</b>	6. RACE <b>Human</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-18-1886</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hoap chas</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>X</b> (Limited Post)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 23 1966</b> to <b>September 28 1971</b> that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>September 28 1971</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
23A. SIGNATURE <b>Soonchul Hong</b>			23B. DATE SIGNED <b>September 28, 1971</b>		
23C. PHYSICIAN'S NAME (Type) <b>SOON CHUL HONG, M.D.</b>			23D. ADDRESS <b>LEVINDALE</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/28/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Hebron Young Men</b>	
24D. LOCATION <b>Balto</b>		24E. STATE <b>Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR <b>Sylvan Lewis &amp; Son</b>	
25D. ADDRESS <b>9610 Reisterstown</b>					

In Levendale 4 yrs. 9 mos.

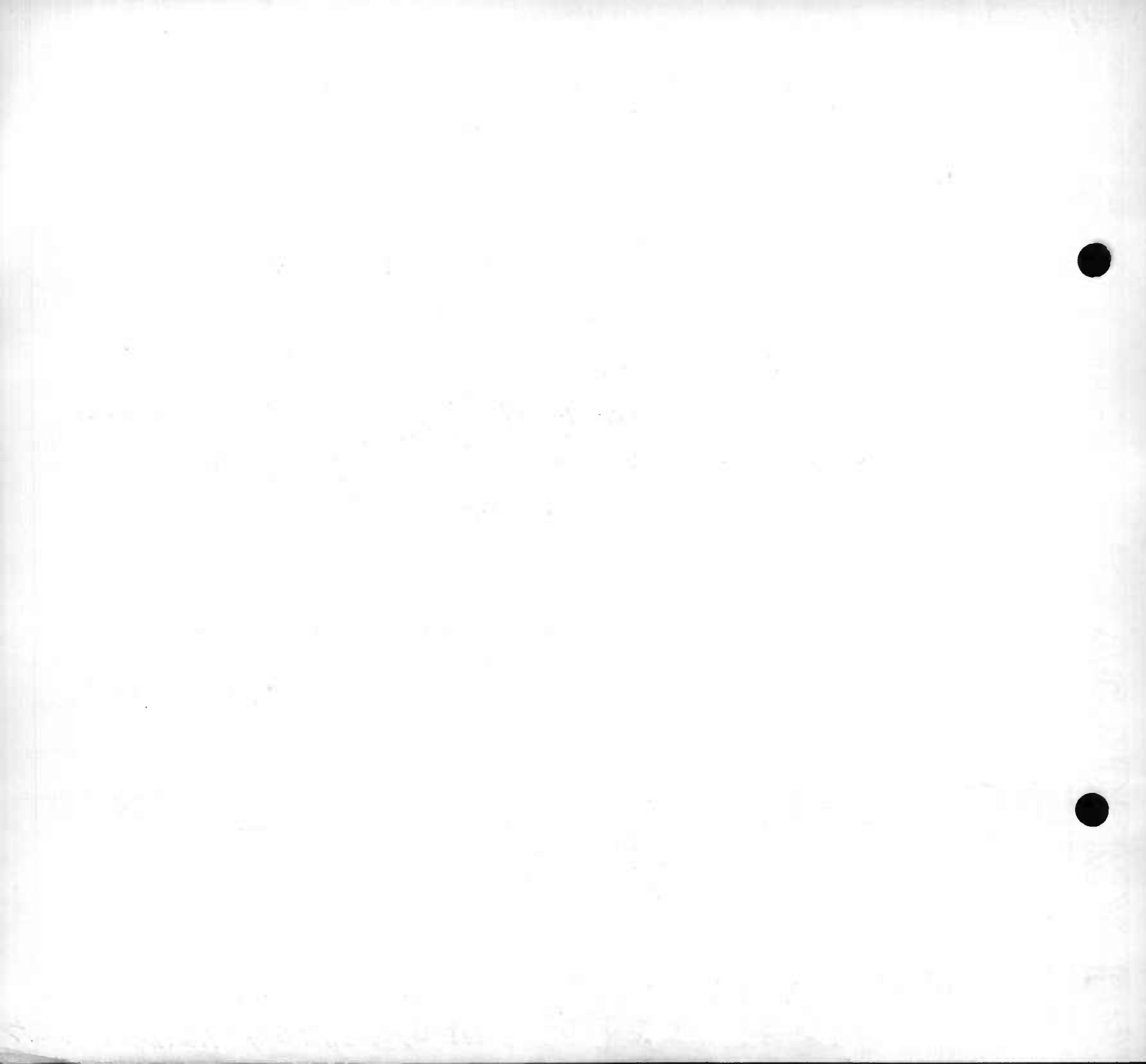
Prior to that in Mt. Sinai N.H.



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9070</u>	
BIRTH NO. <u>71 9070</u>		DELOATCH			
1. NAME OF DECEASED (Type or Print) <u>Romay Deloatch</u>			2. DATE AND HOUR OF DEATH <u>24-Sept-71</u> <u>2:00 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Baltimore Gen Hosp</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2533</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2626 Alaska St</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-22-16</u>	9. AGE (In years lost birthday) <u>35</u>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sand Blaster Coast Guard</u>			11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		
13. FATHER'S NAME <u>Romay Deloatch</u>			14. MOTHER'S MAIDEN NAME <u>Stella Nettie Martin</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-07-0167</u>	17. INFORMANT <u>Stella Deloatch</u> ADDRESS <u>Same</u>		
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic Bronchitis</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Possible Multiple Myeloma</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic Bronchitis</u> (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____		
22. I certify that (I) (this hospital) attended the deceased from <u>12-Sept-71</u> to <u>24-Sept-71</u> that (I) (we) last saw the deceased alive on <u>24-Sept-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard E. Fisker MD</u>				23B. DATE SIGNED <u>24-Sept-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Richard E. Fisker MD</u>				23D. ADDRESS <u>South Balt. Gen. Hosp -</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9/29/71</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus mem. pk.</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore MD.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 29 1971</u>		25B. NAME OF REGISTRAR <u>Robert C. Taylor MD</u>	25C. FUNERAL DIRECTOR <u>Charles Phillips</u> ADDRESS <u>1727 N. Monument</u>		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9071</span>	
71 9071				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ELLEN R. PARKER		SEPTEMBER 22, 1971 2:30 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 509 N. MOUNT STREET			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
			C. CITY OR TOWN BALTIMORE,		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 509 N. MOUNT STREET		
5. SEX Female	6. RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec-7-1900	9. AGE (In years last birthday) 70	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) EASTERN, MARYLAND	
13. FATHER'S NAME WALTER ROBERTS			12. CITIZEN OF WHAT COUNTRY? U S A		
14. MOTHER'S MAIDEN NAME KATE HART					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-44-8287		17. INFORMANT Mrs. Grace Hall- 509 N. Mount Street	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC FAILURE (B) DUE TO, OR AS A CONSEQUENCE OF: GENERALIZED ARTERIO SCLEROSIS (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Approx. 4 yrs 6 wks UNK	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1959 19 to Sept 22, 1971 that (I) (we) last saw the deceased alive on Sept. 22, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE N. Alan Harris, M.D.				23B. DATE SIGNED 9/24/71	
23C. PHYSICIAN'S NAME (Type) N. Alan Harris, M.D.				23D. ADDRESS 4200 Edmondson Ave, Balt., MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-27-71		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY	
				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 29 1971		25B. NAME OF REGISTRAR Robert E. Taylor, MD.		25C. FUNERAL DIRECTOR Arlington S. Phillips-1727 N. Monroe st-21217	
				ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

71 9072		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9072	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>GEORGE SALMON</b>		2. DATE AND HOUR OF DEATH <b>Sept 23, 1971 10:00 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1604</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL, 730 ASHBURTON ST, BALTIMORE, MD 21216.</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>2017 Hatters Avenue</b>			
5. SEX <b>M</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/17/11</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>S.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>251-03-5989</b>		17. INFORMANT <b>Elizabeth Salmon</b>	
				ADDRESS <b>same</b>	
18. <b>486 X 1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>SEPTICEMIC SHOCK</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>PNEUMONIA</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/27/71</b> to <b>9/23/71</b> that (I) (we) last saw the deceased alive on <b>9/23/1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Azad Cader</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Sept 23, 1971</b>	
23C. PHYSICIAN'S NAME (Type) <b>AZAD CADER</b>		23D. ADDRESS <b>Lutheran Hospital, Balto, Md 21216.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-27-71</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem Park</b>	
24D. LOCATION <b>Balto. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, MD.</b>		25C. FUNERAL DIRECTOR <b>William Phillips</b>	
				ADDRESS <b>1227 N. Monroe St.</b>	

12-29

1942

1942

MD

1017 HOSPITAL  
BUTTERFIELD

1017 HOSPITAL

M  
MERO

W 24

S.C.

W 24

1017 HOSPITAL

1017 HOSPITAL

1017 HOSPITAL

1017 HOSPITAL

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 71 9073

BIRTH NO. 71-9073-16103

1. NAME OF DECEASED  
(Type or Print)

BROWN, KENNETH C  
BABY BOY

2. DATE AND HOUR OF DEATH

11 AM 9/25/71

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL

38

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland

2001

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

1815 W. Mulberry St.

5. SEX

M

6. RACE

N

7. MARRIED ☐

NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

9/22/71

9. AGE (in years  
last birthday)

2

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

2 2

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

NOT APPLICABLE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

KENNETH BROWN

14. MOTHER'S MAIDEN NAME

PARRY BOURMAN

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Perry Brown Same

ADDRESS

18. 776.2 I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

RESPIRATORY DISTRESS SYNDROME 3 DAYS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) PREMATURITY

DUE TO, OR AS A CONSEQUENCE OF:

3 DAYS

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED

IN CERTIFYING CAUSES OF DEATH?

NO

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐ Not While  
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/23 1971 to 9/25 1971

that (I) (we) last saw the deceased alive on 9/25 1971 and that (in my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Kenneth V. Eden, M.D.

DEGREE

Attending  
Phys. ☐

Med.  
Director ☐

Staff  
Phys. ☐

23B. DATE SIGNED

9/25/71

23C. PHYSICIAN'S  
NAME (Type)

KENNETH V. EDEN M.D. DEGREE

23D. ADDRESS

UNIVERSITY OF MARYLAND HOSPITAL  
BALTO., MD.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

9/28/71

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cemetery Baltimore

24D. LOCATION

(City, town, or county)

(State)

MD.

25A. DATE REC'D BY HEALTH DEPT.

SEP 29 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

William B. Phelps 1727 N. Main St.

ADDRESS





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

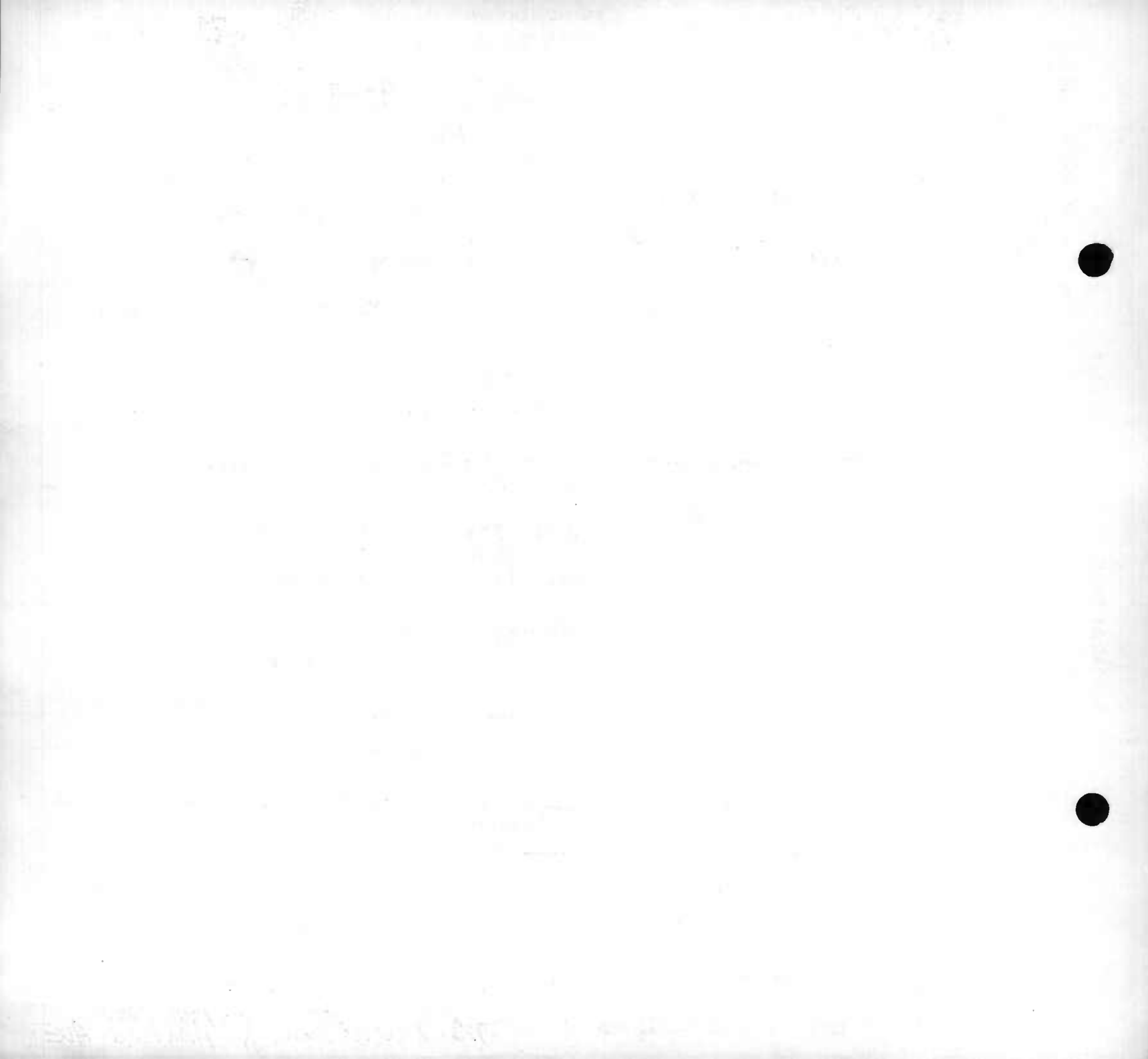
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9074</u>	
BIRTH NO. <u>71 9074</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>PAULINE L. POLISZUK</u> <u>PAULINE POLISZUK</u>			2. DATE AND HOUR OF DEATH <u>27 SEPT 1971</u>   <u>0100 A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MONTABELLO STATE HOSP.</u> <u>BALTIMORE, MARYLAND</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>102</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>23 S. LINWOOD AVE.</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-95</u>	9. AGE (In years last birthday) <u>76</u>	10. UNDER 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Charwoman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Office Build'g.</u>	11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>No</u>
13. FATHER'S NAME <u>Theodore Lewko</u>			14. MOTHER'S MAIDEN NAME <u>Anna Kurylo</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-10-5971A</u>	17. INFORMANT <u>Mrs. Anne Kany, 9305 Montego Ave. 21234</u>		
18. <u>796-9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PNEUMONIA (?)</u> (B) <u>CONGESTIVE HEART FAILURE</u> CHRONIC DUE TO, OR AS A CONSEQUENCE OF: (C) <u>TRAUMATIC BRAIN INJURY</u> 2 1/2 YRS.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <u>MAY 1969</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>2-30</u> 19 <u>69</u> to <u>27 SEPT.</u> 19 <u>71</u> that (I) last saw the deceased alive on <u>26 SEPT</u> 19 <u>71</u> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Bruce A. Mallin, M.D.</u>				23B. DATE SIGNED <u>27 Sept 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>Bruce A. Mallin</u>				23D. ADDRESS <u>MONTABELLO STATE HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/30/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Michael's</u>	
24D. LOCATION <u>Baltimore,</u>		24E. LOCATION (County or county) (State) <u>Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 29 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Tully, R.D.</u>		25C. FUNERAL DIRECTOR <u>M.F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9075</u>	
<b>BIRTH NO.</b> <u>R-160 71 9075</u>		<b>1. NAME OF DECEASED</b> (Type or Print) <u>MAX. RIVERO</u>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <u>Lutheran Hospital, 730 Ashburton St., Baltimore, Md 21216.</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>9-27-71</u> <u>10:20 P.M.</u> <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1506</u> <b>C. CITY OR TOWN</b> <u>Baltimore</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>2827. W. North avenue</u>			
<b>5. SEX</b> <u>M</u>	<b>6. RACE</b> Other <input checked="" type="checkbox"/> Mexican <input checked="" type="checkbox"/>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10-28-1898</u>	<b>9. AGE</b> (In years last birthday) <u>72</u>	<b>10. Under 1 Yr.</b> Months: Days: <b>11. Under 24 Hrs.</b> Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Seaman</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Mexico</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA.</u>		<b>13. FATHER'S NAME</b> <u>Susano Rivera</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Gertrudis Haro</u>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>216-12-2371A</u>		<b>17. INFORMANT ADDRESS</b> <u>Mrs. Rose Rivero 2827 W. North Ave. 21216</u>			
<b>1B. CAUSE OF DEATH</b>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last.				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I</b> <u>BILATERAL PNEUMONIA.</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>and TOXIC ILEUS &amp; DEHYDRATION</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>DUE TO ENTEROCOLITIS.</u> (C)					
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <u>DEHYDRATION</u>					
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <u>no</u>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>					
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from on <u>9/27/1971</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>9/27/71</u> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>Azad Cadar</u>				<b>23B. DATE SIGNED</b> <u>9/27/71</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>AZAD CADAR</u>				<b>23D. ADDRESS</b> <u>Lutheran Hospital, Balto, Md 21216.</u>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>24B. DATE</b> <u>10-1-71</u>		<b>24C. NAME of CEMETERY or CREMATORY</b> <u>Arbutus Memorial Park, Inc.</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Maryland</u>					
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>SEP 29 1971</u>		<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Jaber, Md.</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Marshall W. Jones, Jr.</u>	
<b>25D. ADDRESS</b> <u>HARFORD AVE.</u>					



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-452 71 9076		BALTIMORE CITY HEALTH DEPARTMENT		71 9076
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.
1. NAME OF DECEASED (Type or Print) <i>Cullings, Anna Marie</i>		2. DATE AND HOUR OF DEATH <i>9/28/71 7:30 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hosp.</i>		A. STATE <i>Maryland</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>31 4940 Eastern Avenue</i>		B. COUNTY <i>1509</i>		
Baltimore, Maryland 21224		C. CITY OR TOWN <i>Baltimore</i>		
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <i>3812 Bonner Rd. 21216</i>		
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-24-16</i>	9. AGE (In years last birthday) <i>55</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maid</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Bank</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John Duvall</i>		
14. MOTHER'S MAIDEN NAME <i>Marie Harper</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>214-03-4909</i>		17. INFORMANT ADDRESS <i>Mr. Alton Cullings 3812 Bonner Road</i>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Hodgkins Disease</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. DATE OF OPERATION		19A. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>4 Sept 71</i> to <i>28 Sept 71</i> that (I) (we) last saw the deceased alive on <i>28 Sept 71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <i>Gary M Kammer MD</i>		23B. DATE SIGNED <i>28 Sept 1971</i>		23C. PHYSICIAN'S NAME (Type) <i>Gary M Kammer MD</i>
23D. ADDRESS <i>4940 Eastern Avenue</i>		23E. ADDRESS <i>BCH Baltimore, Md. 21224</i>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <i>10-2-71</i>	24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Memorial Park</i>	24D. LOCATION <i>Baltimore Co. Maryland</i>	(State)
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 29 1971</i>	25B. NAME OF REGISTRAR <i>Barbara B. Lee</i>	25C. FUNERAL DIRECTOR <i>NUSTER FUNERAL HOME</i>	ADDRESS <i>3035 W. NORTH AVE.</i>	

RECEIVED BY THE U.S. DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D.C. 20240

**FUNERAL DIRECTOR: IMPORTANT**

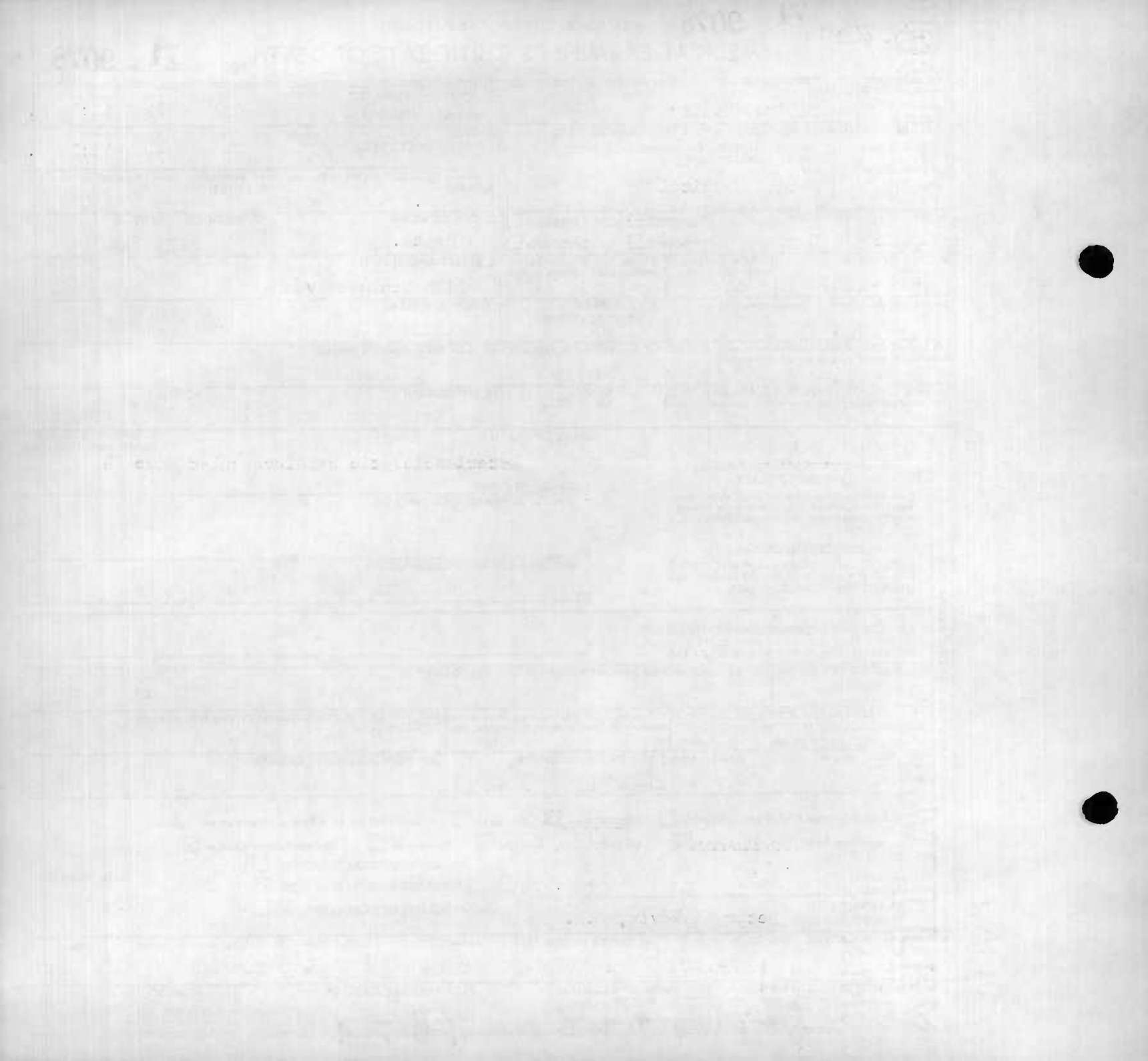
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 9077	
CERTIFICATE OF DEATH				REG. NO. 71 9077	
BIRTH NO. <u>S-140 71 9077</u>		1. NAME OF DECEASED (Type or Print) <u>EDWARD FRANK SHIPLEY JR.</u>		2. DATE AND HOUR OF DEATH <u>9/23/71</u> <u>7<sup>50</sup></u> <u>A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1504</u>		5. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <u>Male</u>		7. RACE <u>Negro</u>		8. DATE OF BIRTH <u>4-16-1914</u>	
9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (in years last birthday) <u>57</u>		11. Under 1 Yr. Months Days 12. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Md. Drydock</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Edward F. Shipley Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Veronica Upheur</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-14-4717</u>		17. INFORMANT <u>Mrs. Elizabeth M. Shipley</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Adenocarcinoma of lung</u>		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory failure</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>5 years</u>	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</u>		21. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Institutionally medical examined) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/21</u> 19 <u>71</u> to <u>9/23</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/22</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <u>Thomas J. Schnitzer</u> DEGREE		23B. DATE SIGNED <u>9/23/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Thomas J. Schnitzer</u> DEGREE		23D. ADDRESS <u>John Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-27-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>	
24D. LOCATION <u>Baltimore Co. Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 29 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>MUTTER FUNERAL HOME</u>		25D. ADDRESS <u>3035 W. NORTH AVE.</u>			





BIRTH NO.		71 9078		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 71 9078	
1. NAME OF DECEASED (Type or Print) Mildred Bailey				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 9 Day 23 Year 71		Hour 12:30 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital				3. DATE PRONOUNCED DEAD		Month 9 Day 23 Year 71		Hour 12:30 a.m.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2788				6. SEX female		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 6-16-1907				10. AGE (in years lost birthday) 64		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Johnson				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		15. MOTHER'S MAIDEN NAME Hughes		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.				18. INFORMANT Mr. Frederick A. Bailey		ADDRESS 5228 Denmore Avenue		19. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no				22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				ACTUAL EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/25/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-27-1971		24C. NAME OF CEMETERY or CREMATORY St. Luke Cemetery		24D. LOCATION (City, town, or county) Reisterstown		(State) Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 29 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AVE			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				71 9079	
R-200 71 9079				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		RICE, HOWARD T.		Sept 27 1971 7 <sup>20</sup> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hospital 44			A. STATE Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2131 Homewood Ave		
5. SEX male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/06	9. AGE (In years last birthday) 65	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) custodian		10B. KIND OF BUSINESS OR INDUSTRY Kennson Apt.		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME Nicholas Rice Sr.			14. MOTHER'S MAIDEN NAME Ellen Bailey		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-9588		17. INFORMANT Mrs. Rebecca Miller 2131 Homewood Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 185X I Intestinal obstruction 2 days			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. prostatic cancer = metastasis 1 year					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 27 1971 to Sept 27 1971 and that (I) (we) last saw the deceased alive on Sept 27 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Wang Teh-Ching				23B. DATE SIGNED Sept 27 1971	
23C. PHYSICIAN'S NAME (Type) WANG TEH-CHING MD				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-2-71		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 29 1971		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR MUTUAL FUNERAL HOME 3035 W. NORTH AVE	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71</u> <u>9080</u>	
BIRTH NO. <u>H-623</u> <u>71</u> <u>9080</u>					
1. NAME OF DECEASED (Type or Print) <u>Pauline Hairston</u>		2. DATE AND HOUR OF DEATH <u>9-25-71</u>   <u>9.10 P.M.</u> <u>M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Keswick Home For Incurables</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1307</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1020 W. 42nd Street</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-14-1893</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Greenway Dining</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Albert T. Cassell</u>			
14. MOTHER'S MAIDEN NAME <u>Charlotte Washington</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>219-18-0771</u>		17. INFORMANT <u>Mr. Oliver B. Cassell</u> ADDRESS <u>1301 Delaware Ave</u>			
18. <u>250.9</u> I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF:				<u>Minutes</u>	
(B) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF:				<u>Years</u>	
(C) <u>Diabetes mellitus</u>				<u>Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Osteoarthritis</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>July 22</u> 19 <u>70</u> to <u>Sept 25</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>Sept 25</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>RK Gundry MD</u>				23B. DATE SIGNED <u>9-27-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>RK Gundry MD</u>		23D. ADDRESS <u>2 W University Pkwy Balt Md</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-29-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>UNION FUNERAL HOME</u> ADDRESS <u>3035 W. NORTH AVE.</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-600 71 9081		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		REG. NO. 71 9081	
1. NAME OF DECEASED (Type or Print) <b>Jessie Curry</b>		2. DATE AND HOUR OF DEATH <b>September 28, 1971 10:20 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Good Samaritan Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>810 N. CHAPEL ST</b>	
5. SEX <b>F</b>	6. RACE <b>B</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR. 13, 1913</b> 9. AGE (in years last birthday) <b>58</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LAB. TECH.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>	11. BIRTHPLACE (State or foreign country) <b>CHESTER, S.C.</b>
13. FATHER'S NAME <b>HENRY</b>		14. MOTHER'S MAIDEN NAME <b>JESSIE THOMPSON</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>124-20-4107</b>	17. INFORMANT <b>MAGDALENA GARRETT</b> ADDRESS
18. CAUSE OF DEATH <b>157.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>XXXX</b> 20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 week</b> <b>3 months</b>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <b>XXX</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>XXX</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>XXX</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>XXX</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>XXX</b>		21F. HOW DID INJURY OCCUR? <b>XXX</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>September 16, 1971</b> to <b>September 28, 1971</b> that (I) <del>(we)</del> last saw the deceased alive on <b>September 28, 1971</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.			
23A. SIGNATURE <b>George H. Sack, Jr.</b> DEGREE <b>MD</b>		23B. DATE SIGNED <b>9/28/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>George H. Sack, Jr., M.D.</b>		23D. ADDRESS <b>601 N. Broadway, Balto., Md., 21205</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>10/2/71</b>	24C. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PARK</b>	24D. LOCATION (City, town, or county) (State) <b>BALTO MD</b>
25A. DATE DEATH BY HEALTH DEPT. <b>SEP 29 1971</b>	25B. NAME OF REGISTRAR <b>Robert E. Sack, M.D.</b>	25C. FUNERAL DIRECTOR <b>DAVID E. GLOVER</b> ADDRESS <b>712 E. NORTH AVE</b>	

bm



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

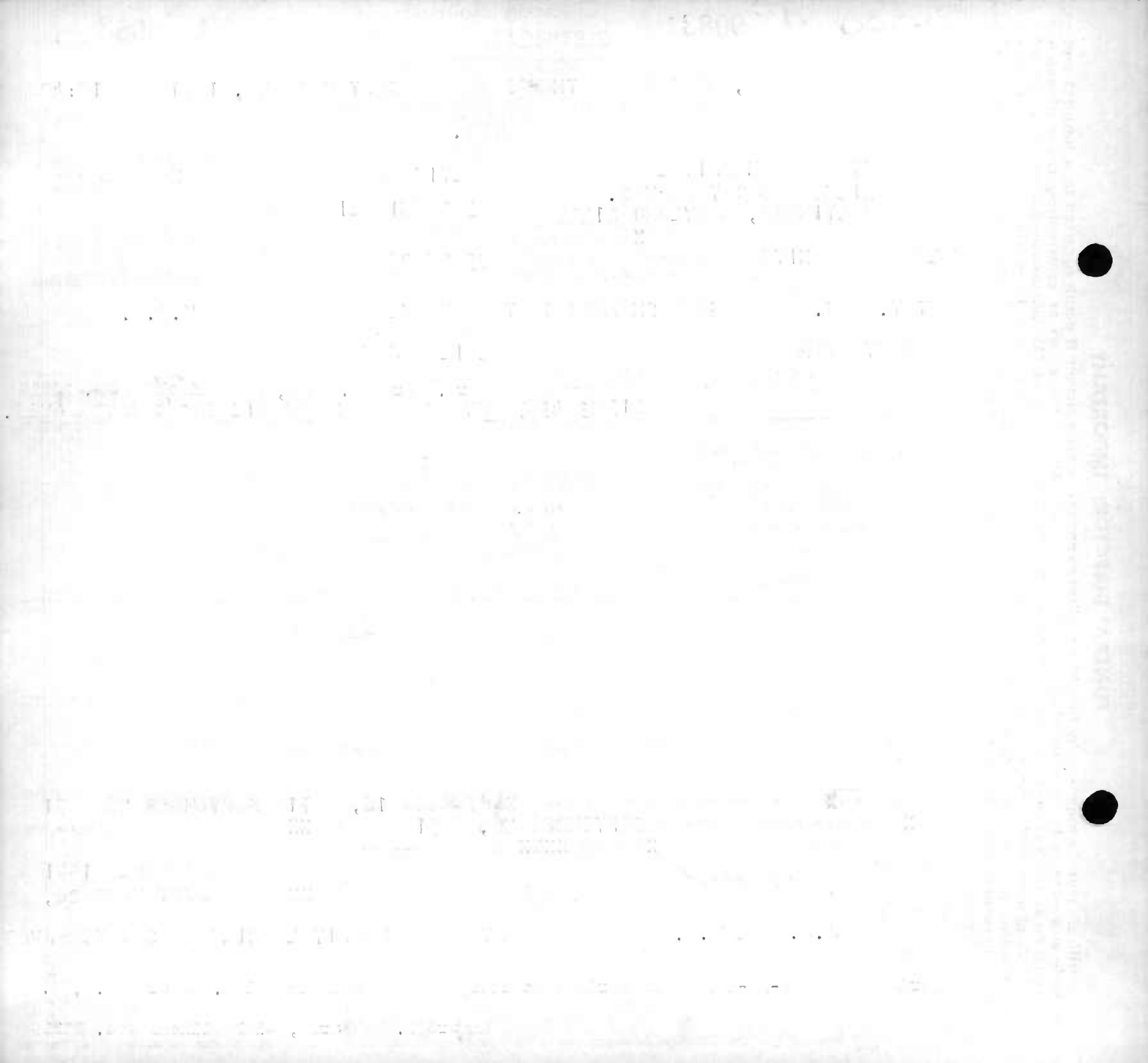
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">71 9082</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">C-632 71 9082</span> <span>21-18248</span> </div>					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Curtis, Baby Boy</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">Sept. 27th, 1971 4:45 AM.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">1601</span>		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">33 Johns Hopkins Hospital</span>			C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <span style="font-size: 1.2em;">910 Harlom</span>					
5. SEX <span style="font-size: 1.2em;">m</span>	6. RACE <span style="font-size: 1.2em;">L Negro</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">9-24-71</span>	9. AGE (in years last birthday) <span style="font-size: 1.2em;">2</span>	10. Under 1 Yr. Months: Days: Hours: Min. <span style="font-size: 1.2em;">2</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">—</span>	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore, Md.</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">Johns Hopkins Hospital</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Thomas Chossin</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Curtis</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. <span style="font-size: 1.2em;">772.01</span> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Cardio pulmonary Arrest</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">0</span>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <span style="font-size: 1.2em;">Probable Intra Ventricular Bleed</span> DUE TO, OR AS A CONSEQUENCE OF:		<span style="font-size: 1.2em;">45 min</span>
			(C) <span style="font-size: 1.2em;">Extreme Prematurity (1540g)</span>		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <span style="font-size: 1.2em;">NO</span>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">9/24</span> <span style="font-size: 1.2em;">19 71</span> to <span style="font-size: 1.2em;">9/27</span> <span style="font-size: 1.2em;">19 71</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">9/27</span> <span style="font-size: 1.2em;">19 71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">A. G. Kasselberg, M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">9/27/71</span>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<span style="font-size: 1.2em;">Alfred G. Kasselberg, M.D.</span>		<span style="font-size: 1.2em;">The Johns Hopkins Hospital</span>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)		
<span style="font-size: 1.2em;">Cremation</span>	<span style="font-size: 1.2em;">9/28/71</span>	<span style="font-size: 1.2em;">Johns Hopkins Hospital</span>	<span style="font-size: 1.2em;">601 N Broadway Balto, Md.</span>		
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">SEP 29 1971</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">HOSPITAL DISPOSAL</span>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 9083</b>	
D-500 <b>71 9083</b>		<b>CERTIFICATE OF DEATH</b>			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<b>DEAN, BENSON THOMAS</b>		<b>SEPTEMBER 26, 1971 10:40 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVES. BALTIMORE, MARYLAND 21229</b>		A. STATE <b>MD.</b>		B. COUNTY	
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>03 25 05</b>		9. AGE (in years last birthday) <b>66</b>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STAT. ENG.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>GOOD SHEPARD CENTER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>ROBERT DEAN</b>		14. MOTHER'S MAIDEN NAME <b>LEILA JOY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>21303 4387</b>		17. INFORMANT <b>Mrs. Sarah C. Dean, 3608 Hinelane Rd. 21229</b>	
				ADDRESS <b>ST AGNES RECORDS WILKENS &amp; CATON AVES.</b>	
18. <b>189.0 I</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Heart arrest</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>negative sepsis?</b> DUE TO, OR AS A CONSEQUENCE OF: <b>kidney malignancy</b>			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>cyst operation 2 weeks ago</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>SEPTEMBER 26, 19 71</b> to <b>SEPTEMBER 26, 19 71</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>SEPTEMBER 26, 19 71</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE <b>J.J. Mol</b>		23B. DATE SIGNED <b>1971 SEPTEMBER 26,</b>		23C. PHYSICIAN'S NAME (Type) <b>J.J. MOL M.D.</b>	
		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-30-1971</b>		24C. NAME of CEMETERY or CREMATORY <b>Meadowridge Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Washington Blvd. Howard Co., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>	
25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		25D. ADDRESS <b>4107 Wilkens Ave. 21229</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9084</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">A-416 71 9084</span> <span style="font-size: 1.5em;">1</span> </div>					
<div style="display: flex; justify-content: space-between;"> <div> <b>BIRTH NO.</b>  <b>1. NAME OF DECEASED</b>                      (Type or Print) <span style="font-size: 1.2em;">ALBRIGHT CHARLES ALLEN</span> </div> <div> <b>2. DATE AND HOUR OF DEATH</b>  <div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.2em;">09/26/71</span> <span style="font-size: 1.2em;">2:15PM</span> </div> </div> </div>					
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>  <span style="font-size: 1.5em;">40</span> <span style="font-size: 1.2em;">ST AGNES HOSPITAL</span> </div> <div> <b>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b> </div> </div>			<b>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</b> <div style="display: flex; justify-content: space-between;"> <div> <b>A. STATE</b>  <span style="font-size: 1.2em;">MARYLAND</span> </div> <div> <b>B. COUNTY</b>  <span style="font-size: 1.5em;">2551</span> </div> </div>		
<b>5. SEX</b> <div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.2em;">MALE</span> <span style="font-size: 1.2em;">WHITE</span> </div>			<b>6. RACE</b> <div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.2em;">MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></span> <span style="font-size: 1.2em;">WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></span> </div>		<b>7. DATE OF BIRTH</b> <span style="font-size: 1.2em;">08/29/21</span>
<b>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <span style="font-size: 1.2em;">WELDER</span>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">CONSTRUCTION</span>		<b>9. AGE (In years last birthday)</b> <span style="font-size: 1.2em;">50</span>
<b>11. BIRTHPLACE (State or foreign country)</b> <span style="font-size: 1.2em;">PENNSYLVANIA</span>			<b>12. CITIZEN OF WHAT COUNTRY</b> <span style="font-size: 1.2em;">U S A</span>		
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">WILLIAM ALBRIGHT</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">MARY LENHART</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</b> <span style="font-size: 1.2em;">YES WW2</span>			<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">174-16-0274</span>		<b>17. INFORMANT ADDRESS</b> <span style="font-size: 1.2em;">ST AGNES HOSPITAL BALTO MD 21229</span>
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div style="width: 50%;"> <b>CAUSE OF DEATH</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>(A) IMMEDIATE CAUSE</b>                      DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.5em;">Respiratory Failure</span> </div> <div> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b>  <span style="font-size: 1.5em;">Subarachnoid Hemorrhage</span> </div> <div> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>  <span style="font-size: 1.5em;">Aneurysm Cerebral artery</span> </div> </div> </div> <div style="width: 5%;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> </div> </div>					
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">9-29-71</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">Sub Ineurysm</span>		<b>20A. AUTOPSY? (Yes or No)</b> <span style="font-size: 1.2em;">NO</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</b>		<b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> <div style="display: flex; justify-content: space-between;"> <span>While At Work <input type="checkbox"/></span> <span>Not While At Work <input type="checkbox"/></span> </div>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (X) (this hospital) attended the deceased from <span style="font-size: 1.2em;">09/19/71</span> 19__ to <span style="font-size: 1.2em;">09/26/71</span> 19__ that (X) (we) last saw the deceased alive on <span style="font-size: 1.2em;">09/26/71</span> 19__ end that in (X) (our) opinion death occurred on the date end hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">[Signature]</span>				<b>23B. DATE SIGNED</b>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <span style="font-size: 1.5em;">DR CURTIS H</span>				<b>23D. ADDRESS</b>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">9-30-1971</span>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Lorraine Park Cemetery</span>	
<b>24D. LOCATION</b> <span style="font-size: 1.2em;">Woodlawn, Maryland</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.5em;">SEP 29 1971</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.5em;">[Signature]</span>		<b>25C. FUNERAL DIRECTOR ADDRESS</b> <span style="font-size: 1.2em;">Howard H. Hubbard, 4107 Wilkens Ave. 21229</span>			

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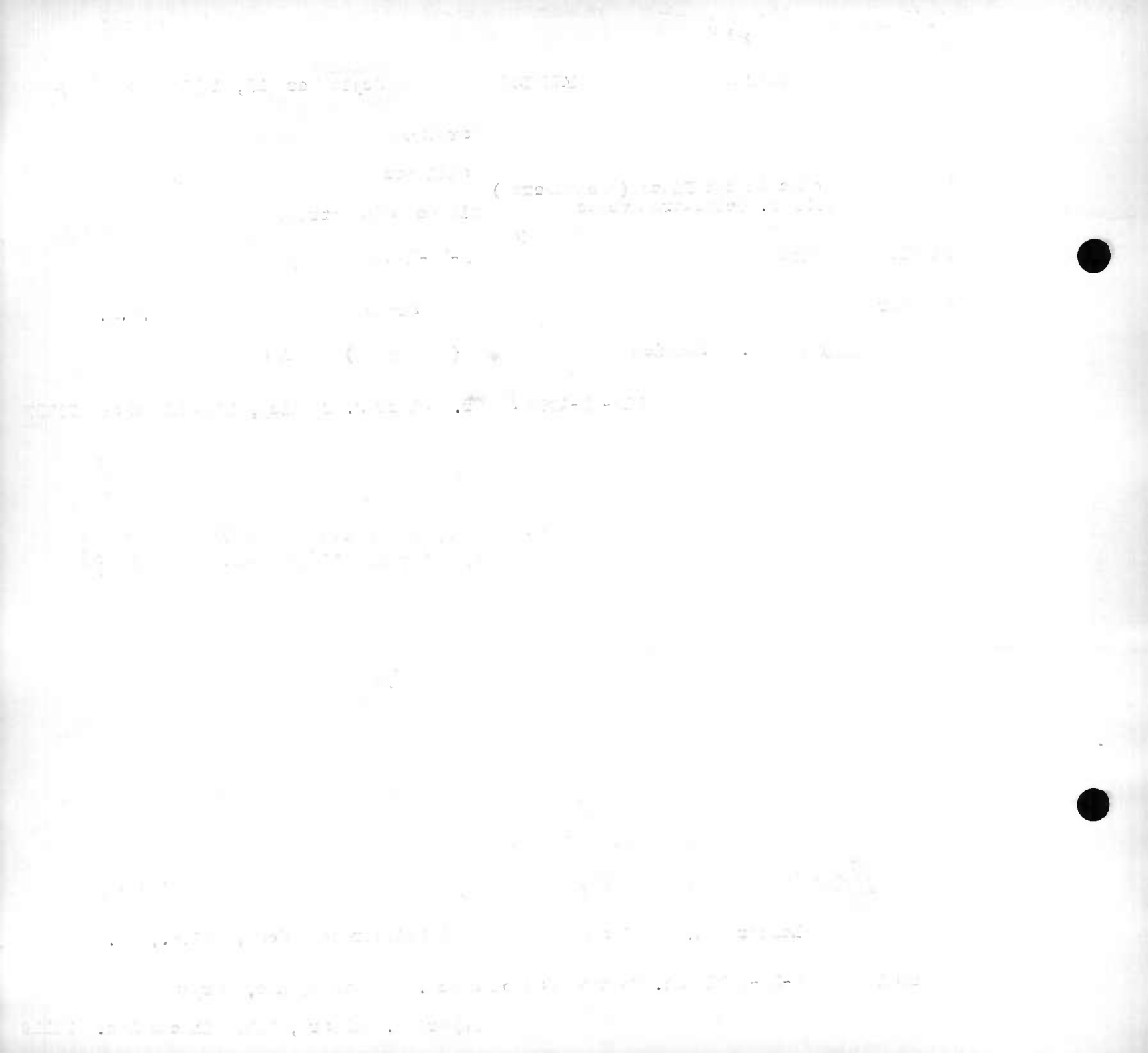
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9085</u>	
7-520 71 9085		BIRTH NO.			
1. NAME OF DECEASED (Type or Print)		BERTHA FENWICK		2. DATE AND HOUR OF DEATH September 25, 1971 8:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  90 House in the Pines (Belvedere) 2525 W. Belvedere Avenue		A. STATE Maryland		B. COUNTY 1605	
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 812 Bentalou Street					
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-26-1884	9. AGE (In years last birthday) 87	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William H. Fenwick		14. MOTHER'S MAIDEN NAME (Unknown) Adams	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 216-07-1300 A		17. INFORMANT Mr. Walter R. Twilley, 1010 Elm Road 21227	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute M.I.</u> <u>Arteriosclerosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinomatous of stomach</u> <u>metastases to liver</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yr.</u> <u>3 yr.</u> <u>2 yr.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 19 1971</u> to <u>Sept 25 1971</u> that (I) (we) last saw the deceased alive on <u>Sept 24 1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lester N. Kolman M.D.</u>		23B. DATE SIGNED 9/28/71			
23C. PHYSICIAN'S NAME (Type) Lester N. Kolman		23D. ADDRESS 6821 Reisterstown Road, Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-29-1971		24C. NAME OF CEMETERY OR CREMATORY St. Georges Catholic Cem.	
24D. LOCATION Valley Lee, Maryland		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	

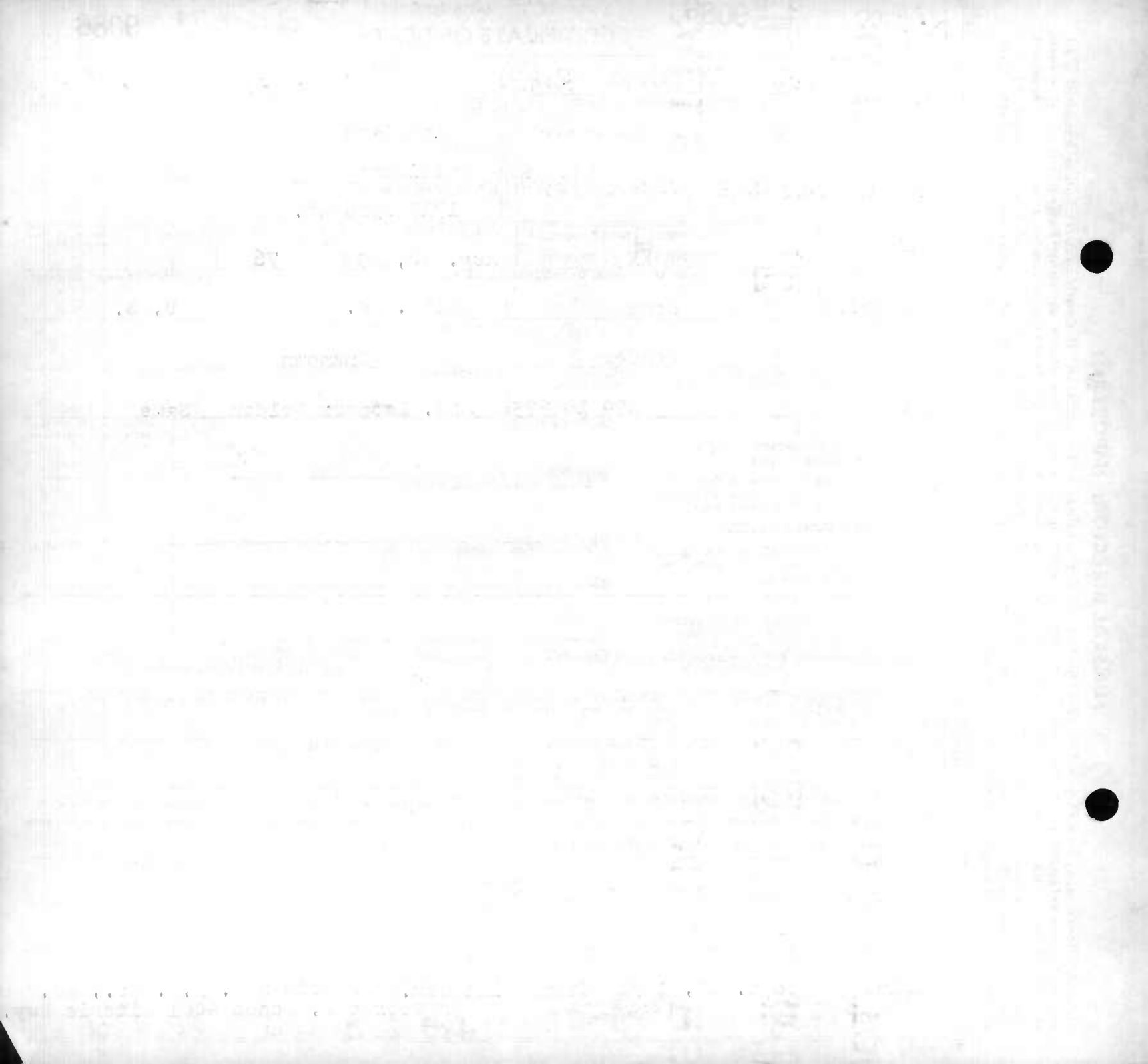




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9086</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">R-412</span>		<b>CERTIFICATE OF DEATH</b>			
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Mary Catherine Rohlf</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">9/24/71</span> <span style="float: right;">6<sup>30</sup> P M.</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">43 South Baltimore General Hospital</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">2404</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">1713 Byrd St.</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">F</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">W</span>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Aug. 10, 1895</span> <span style="float: right;">76</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">76</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">None</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Balto. Md.</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U. S.</span>		<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Bender</span>			
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Unknown</span>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>			
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">279 14 3756</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mrs. Leonora Golden</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">Same</span>			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Impending Arteriosclerotic Cardiovascular disease</span>		<b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">years</span>			
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">II</span>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">years</span>			
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">No</span>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">8<sup>30</sup> AM Sep. 24 19 71</span> <b>to</b> <span style="font-size: 1.2em;">6<sup>30</sup> PM Sep. 24 19 71</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">Sep. 24 19 71</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Susumu Kinjo MD</span>		<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">9/24/71</span>		<b>23C. PHYSICIAN'S NAME (Type)</b> <span style="font-size: 1.2em;">Susumu Kinjo MD</span>	
<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">3001 South Hanover Street, Balto. MD</span>		<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>			
<b>24B. DATE</b> <span style="font-size: 1.2em;">Sept. 27, 1971</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Cedar Hill Cem.</span>		<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Ritchie Hwy. A.A. Co. Md.</span>	
<b>25A. DATE RECEIVED BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">SEP 29 1971</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">George J. Gonce</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Done Funeral Service</span>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9087</u>	
BIRTH NO. <u>P-000 71 9087</u>		1. NAME OF DECEASED (Type or Print) <b>ELSIE POE</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>2901 Echodale Ave.</b>		2. DATE AND HOUR OF DEATH <b>September 28, 1971 9A.</b>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2733</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b> 6. RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 4, 1900</b>		9. AGE (In years last birthday) <b>71</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Candy Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Bluefield, W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.S</b>		13. FATHER'S NAME <b>Kelly Faulkner</b>		14. MOTHER'S MAIDEN NAME <b>Americe Poe</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>236-28-8676</b>		17. INFORMANT ADDRESS <b>Mr. Watson B. Poe, Sr. -- Same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH <b>Myocardial Cardiovascular</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION <b>0</b>		20. AUTOPSY? (Yes or No) <b>—</b>		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>—</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 24 1971</b> to <b>Sept 28 1971</b> and that (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James E. White</b>		23B. DATE SIGNED <b>Sept 28/71</b>			
23C. PHYSICIAN'S NAME (Type) <b>JAMES E. WHITE MD</b>		23D. ADDRESS <b>5214 Harford Road - Balto 21214</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/1/71</b>		24C. NAME of CEMETERY or CREMATORY <b>Gardens of Faith</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 30 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck Inc., Balto. Md. 21214</b>	



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BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9088

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elizabeth Rose Sadler		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 9 27 71 4:46 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year 9 27 71 4:46 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1506	
9. DATE OF BIRTH 1/5/1919		10. AGE (In years last birthday) 52	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		13. FATHER'S NAME Frank H. Sellman	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Bertha Bennett	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 219013490	
18. INFORMANT Albert C. Sadler same		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9-28-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/1/71	
24C. NAME OF CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 30 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS Balto. Md.	

8202

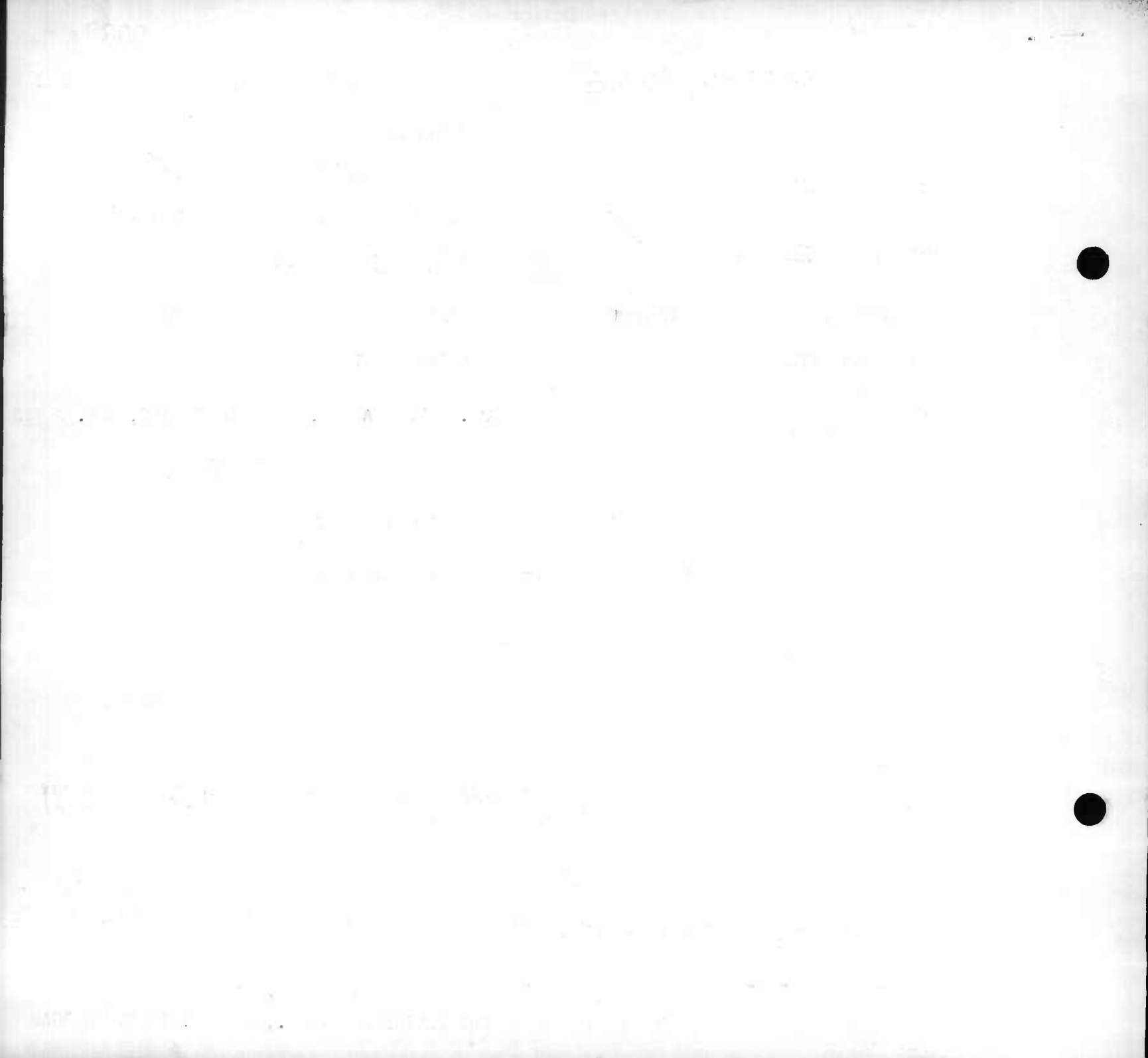
8202

Handwritten signature or initials.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		71 9089		71 9089	
BIRTH NO. <u>S-160</u>		71 9089		71 9089	
1. NAME OF DECEASED (Type or Print) <u>SHAPIRO, BESSIE</u>		2. DATE AND HOUR OF DEATH <u>Sept. 25 - 71</u> <u>11:16 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL</u> <u>42</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2717</u>			
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2500 W. BELVEDERE AVE # 215</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>XXX WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/15/98</u>	9. AGE (In years last birthday) <u>80</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>SOLOMON PATZ</u>			
14. MOTHER'S MAIDEN NAME <u>CELIA ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. RUTH KRAVITZ, 3622 FORDS LANE, APT. A #15</u>			
18. <u>4/11/01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARDIAC ARRHYTHMIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CORONARY INSUFFICIENCY</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>CHF, HYPERTENSION</u> (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 13</u> 19 <u>71</u> to <u>Sept 25</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Sept 25</u> 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C. Thananopavar M.D.</u>		23B. DATE SIGNED <u>Sept. 25/71</u>		23C. PHYSICIAN'S NAME (Type) <u>CHALEMPHOL THANANOPAVARN M.D.</u>	
23D. ADDRESS <u>SINAI HOSPITAL</u>		23E. ADDRESS <u>SINAI HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-27-71</u>		24C. NAME of CEMETERY or CREMATORY <u>BALTIMORE HEBREW</u>	
24D. LOCATION <u>BALTIMORE, MARYLAND</u>		24E. LOCATION <u>BALTIMORE, MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 30 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u>		25C. FUNERAL DIRECTOR <u>SQL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>	

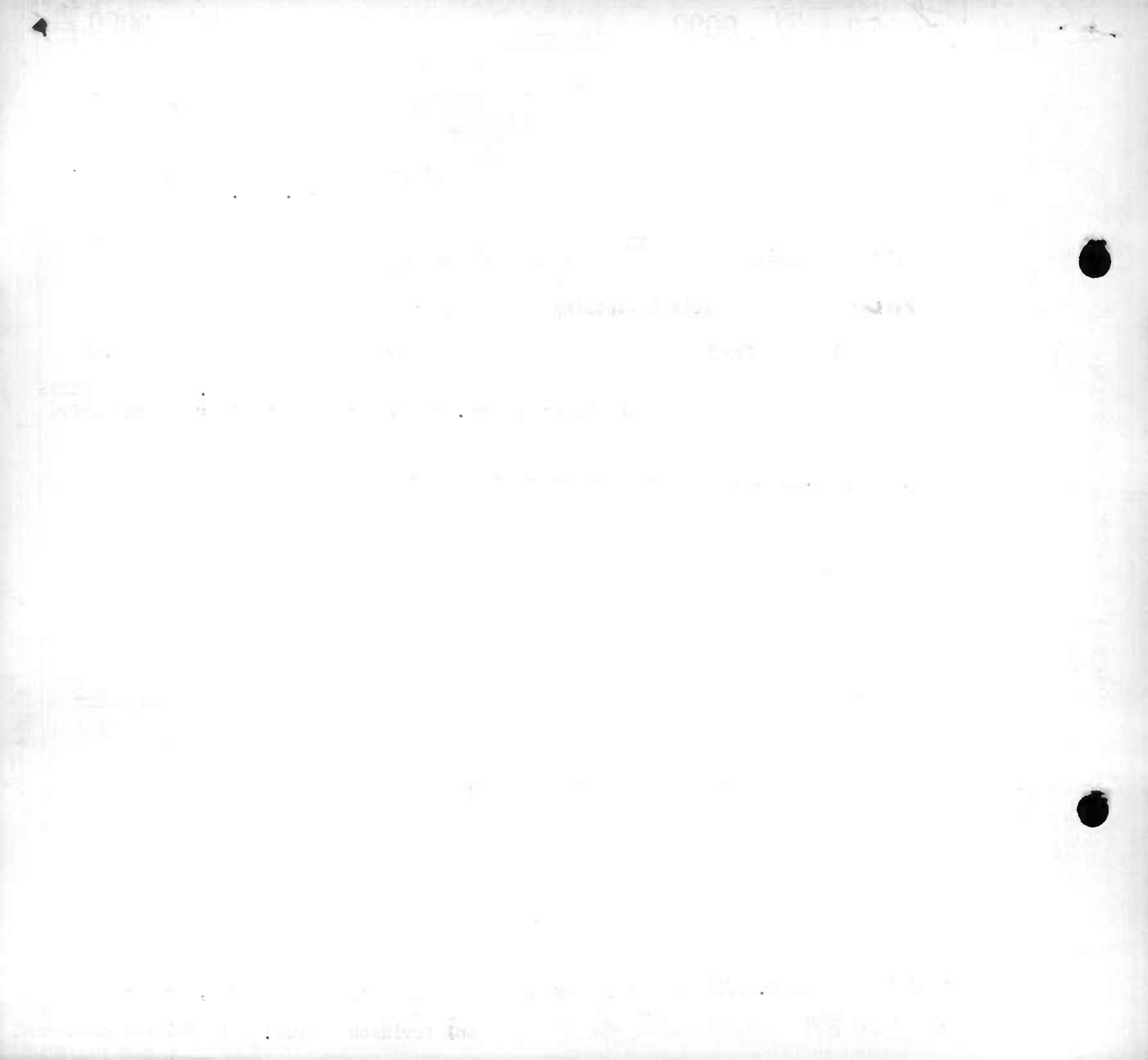




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

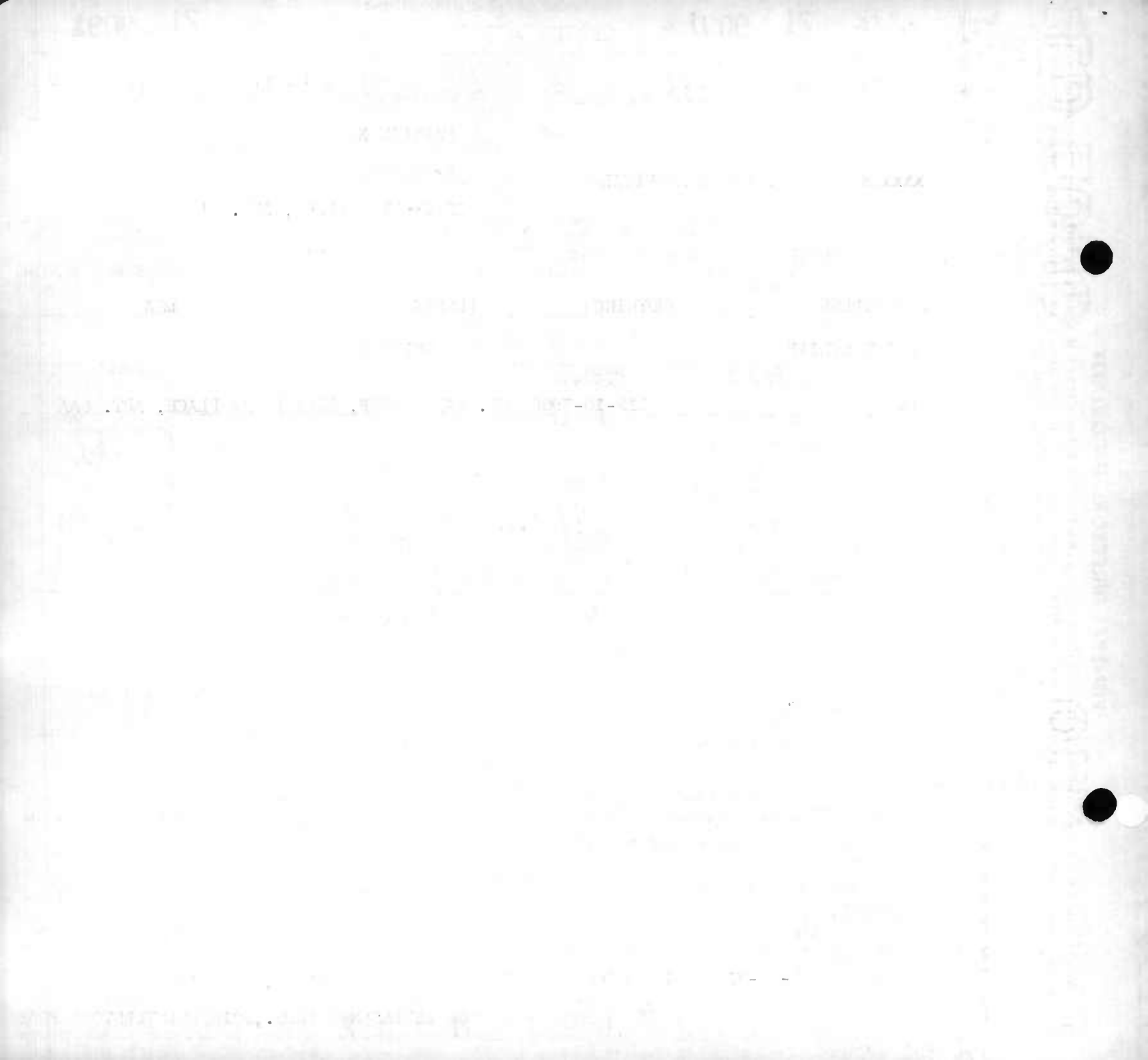
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 9090
7-652 71 9090				
BIRTH NO.				
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
FRANK, CHARLES		9-25-71 12:52 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE, Inc.		A. STATE MD. B. COUNTY BALTD.		
42		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER Apt. 2 B. 6996 Milbrook Park Dr. #15		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <del>XXXX-XX-XX</del>	9. AGE (in years last birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10B. KIND OF BUSINESS OR INDUSTRY Retail Clothing		11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME ? Frank		14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-32-3629		17. INFORMANT Mrs. Jennie Frank 6996 Milbrook Park Drive
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) GASTRIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF: WIDESPREAD METASTASIS (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 9-19-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED POOR		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 9-17-71 to 9-25-71 that (I) (we) last saw the deceased alive on 9-25-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Kathleen M.D.		23B. DATE SIGNED 9-25-71		23C. PHYSICIAN'S NAME (Type) ROBERT E. LIBON M.D.
23D. ADDRESS SINAI HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 26/71		24C. NAME of CEMETERY or CREMATORY Kneseth Israel Anshe Kolk Wolyn
24D. LOCATION Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT. SEP 30 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR S. Levinson & Bros. 6010 Reisterstown Road



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 9091</u>	
BIRTH NO. <u>S-100 71 9091</u>				1. NAME OF DECEASED (Type or Print) <u>Mary Schiff</u>		2. DATE AND HOUR OF DEATH <u>9-24-71 11<sup>10</sup> A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 MARXES UNION MEMORIAL HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1303</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2502 EUTAW PLACE, APT. 6L</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>74</u>		9. AGE (In years last birthday) <u>74</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JACOB SCHIFF</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-10-7996</u>		17. INFORMANT ADDRESS <u>MR. SAM SCHIFF, 2502 EUTAW PLACE, APT. 6AA</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>410.0 I</u> <b>CAUSE OF DEATH</b> <u>Acute Myocardial Infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertensive Cerebrovascular Heart Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Artery Disease</u> (C) <u>Generalized Atherosclerosis</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>- 1 hr.</u> <u>25 years</u> <u>20 years</u> <u>25 years</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u>		20A. AUTOPSY? (Yes or No) <u>0</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>0</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>0</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>0</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>0</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>0</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>Sept. 6th</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>H. William Primakoff, M.D.</u> DEGREE				23B. DATE SIGNED <u>Sept. 24, 1971</u>		23C. PHYSICIAN'S NAME (Type) <u>H. WILLIAM PRIMAKOFF, M.D.</u> DEGREE	
23D. ADDRESS <u>3900 North Charles Street, Balt. Md. 21218</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-26-71</u>		24C. NAME of CEMETERY or CREMATORY <u>BETH JACKOB ANSHE VESHEAR</u>		24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 30 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

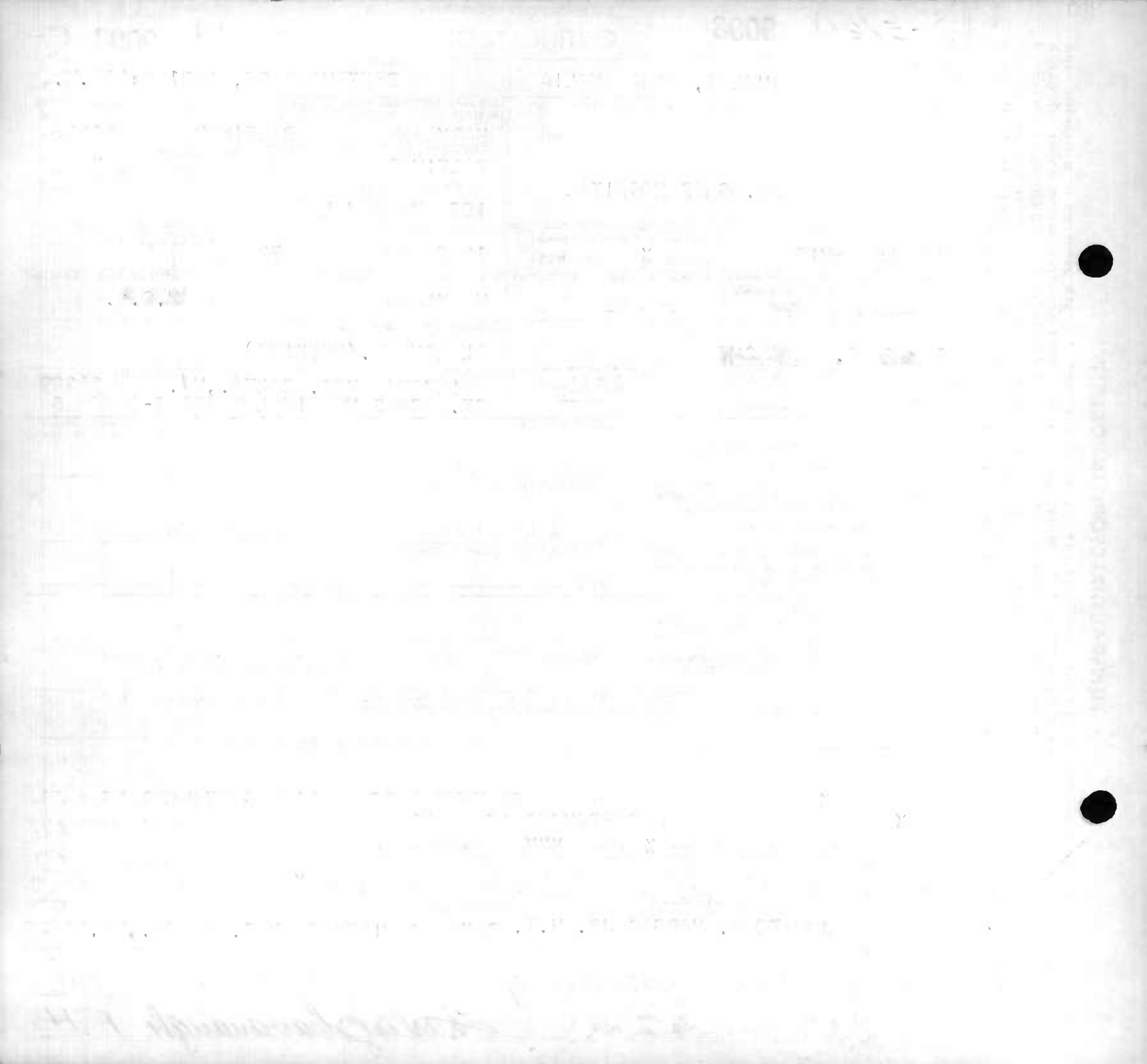
BALTIMORE CITY HEALTH DEPARTMENT				71 9092	
5-53671 9092				REG. NO.	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Schneider, Helen Margaret</u>				2. DATE AND HOUR OF DEATH <u>Sept-28-1971</u> <u>1:25</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>21226</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>South Baltimore General Hospital</u>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1620 Hazel ST</u>					
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June-24-1915</u>	9. AGE (In years last birthday) <u>56</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland ST</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>					
13. FATHER'S NAME <u>John Sitar</u>			14. MOTHER'S MAIDEN NAME <u>Josephine Karbel</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>216-10-6781</u>		17. INFORMANT <u>James Schneider</u> ADDRESS <u>same</u>
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. I) means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  20A. AUTOPSY? (Yes or No)  20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac arrest</u> (B) <u>Bronchogenic Ca, metastatic</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 9</u> 19 <u>71</u> to <u>Sept. 28</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Sept 28</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>yes jph Noh</u>				23B. DATE SIGNED <u>Sept 28/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>DEGREE</u>				23D. ADDRESS <u>DEGREE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10-1-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Bohemian NAT.</u>	
24D. LOCATION <u>HORNER ST. BALTO. MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 30 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Jahn, Jr.</u>		25C. FUNERAL DIRECTOR <u>Charlotte K. Hahn</u>	



# FUNERAL DIRECTOR: IMPORTANT

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HBD		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9093	
D-54671 9093		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DUMLER, ERMA AMELIA		SEPTEMBER 25, 1971 1:11P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		MARYLAND BALTIMORE 21228	
40 ST. AGNES HOSPITAL				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				BALTIMORE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER		105 NUNNERY LANE	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12 09 98	72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEKEEPER		HOME		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
GEORGE F. ALBRECHT		BLANCHE R. (HOPKINS)		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				WILKENS AVES. BALTO., MD. 21229 ST. AGNES HOSPITAL RECORDS-CATON &	
18. 410.9 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Myocardial Infarction			
ANTECEDENT CAUSES		(B) Arteriosclerotic Cardiovascular Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 25 19 71 to SEPTEMBER 25 19 71 that (X) (we) last saw the deceased alive on SEPTEMBER 25 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Donato A. Vargas Jr. M.D.		9-25-71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DONATO A. VARGAS JR. M.D.		CATON & WILKENS AVES. BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		9-29-71		Deerwood Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 30 1971		Robert E. Taylor, M.D.		Harold J. Baranough F.H.	

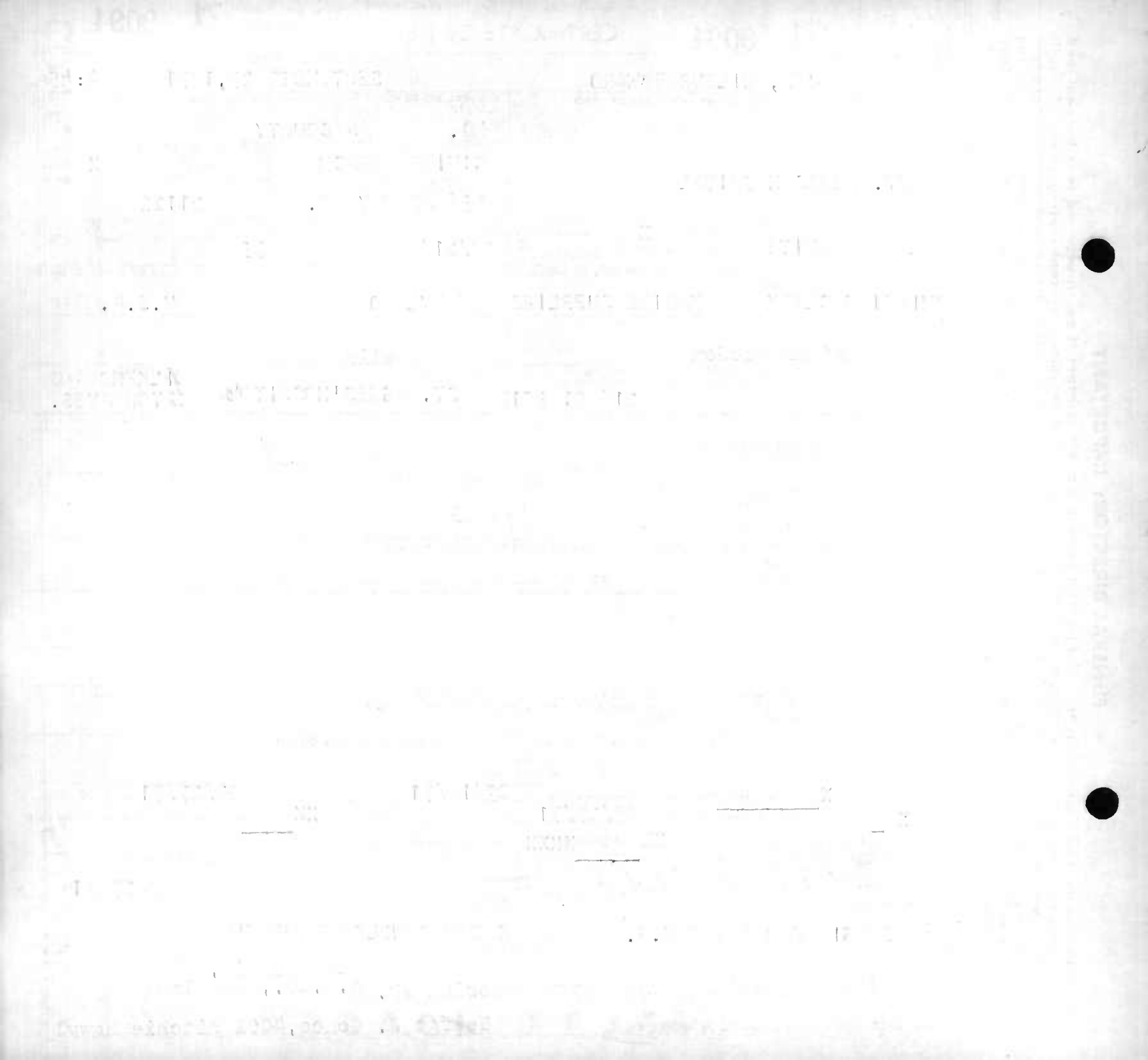




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9094</span>	
W-350 71 9094		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">WOODEN, WILBUR EDWARD</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">SEPTEMBER 27, 1971 4:45A.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">40 ST. AGNES HOSPITAL</span>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MD.</span> B. COUNTY <span style="font-size: 1.2em;">AA COUNTY</span> <span style="font-size: 1.5em;">5200</span>		
			C. CITY OR TOWN <span style="font-size: 1.2em;">RIVIERA BEACH</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">236 ASBURY RD.</span>		<span style="font-size: 1.2em;">21122</span>
5. SEX <span style="font-size: 1.2em;">MALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">05/21/98</span>	9. AGE (in years last birthday) <span style="font-size: 1.2em;">73</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">SHIPPING CLERK</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">MARINE SUPPLIES</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">Arthur Wooden</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Amelia</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">216 01 3517</span>			17. INFORMANT <span style="font-size: 1.2em;">ST. AGNES HOSPITAL</span>		
18. <span style="font-size: 1.5em;">436.9 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">CAUSE OF DEATH</span> <span style="font-size: 1.5em;">Cardiac Arrest</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">C.U.A.</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <span style="font-size: 1.2em;">09/16/71</span> 19 to <span style="font-size: 1.2em;">09/27/71</span> 19 that (X) (we) last saw the deceased alive on <span style="font-size: 1.2em;">09/27/71</span> 19 and that (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Sergio San Pedro M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">09 27 71</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">SERGIO SAN PEDRO M.D.</span>				23D. ADDRESS <span style="font-size: 1.2em;">CATON &amp; WILKENS AVENUE</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">9/29/71</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Glen Haven Memorial Pr</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Glen Burnie, A.A.Co., Maryland</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">SEP 30 1971</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">George J. Conce</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">George J. Conce</span>		ADDRESS <span style="font-size: 1.5em;">4001 Ritchie Hgwy</span>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

8-126 71 9095		BALTIMORE CITY HEALTH DEPARTMENT		71 9095	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>EULA SPICER</i>		2. DATE AND HOUR OF DEATH <i>9-28-71</i> <i>8:10</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>8 UNIV. Md. HOSP.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Harford Co.</i> <i>6200</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>8 UNIV. Md. HOSP.</i>		C. CITY OR TOWN <i>Bel Air</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>FEMALE</i>		6. RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>October 23, 1910</i>		9. AGE (In years last birthday) <i>60</i>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Loggins</i>		14. MOTHER'S MAIDEN NAME <i>Martha Elizabeth Roupe</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>23-38-6800</i>		17. INFORMANT (Husband) <i>838-7225 or 3485</i> ADDRESS <i>Mr. John M. Spicer Bel Air, Maryland 21014</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Myocardial Infarction</i>		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Ruptured spleen</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>vehicular accident</i>		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1-2 days</i> <i>22 days</i> <i>22 days</i>	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
23. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <i>9-6-71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Stomach</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Stomach</i>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>7215 21st + 147</i>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>9-6-71 9:30</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <i>driven through steel sign</i>		22. I certify that (I) (this hospital) attended the deceased from <i>9-28-71</i> to <i>9-28-71</i> and that (I) (we) last saw the deceased alive on <i>9-28-71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Seaton Felchert</i>		23B. DATE SIGNED <i>9-28-71</i>		23C. PHYSICIAN'S NAME (Type) <i>Robert E. Taylor, M.D.</i>	
23D. ADDRESS <i>Bel Air, Harford Co., Maryland 21014</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			
24B. DATE <i>Sept. 30, 1971</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Methodist Church Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Bel Air, Harford Co., Maryland 21014</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 30 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Joseph William Foster</i>	
25D. ADDRESS <i>Bel Air, Maryland 21014</i>		25E. ADDRESS <i>W. Broadway &amp; Williams St.</i>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

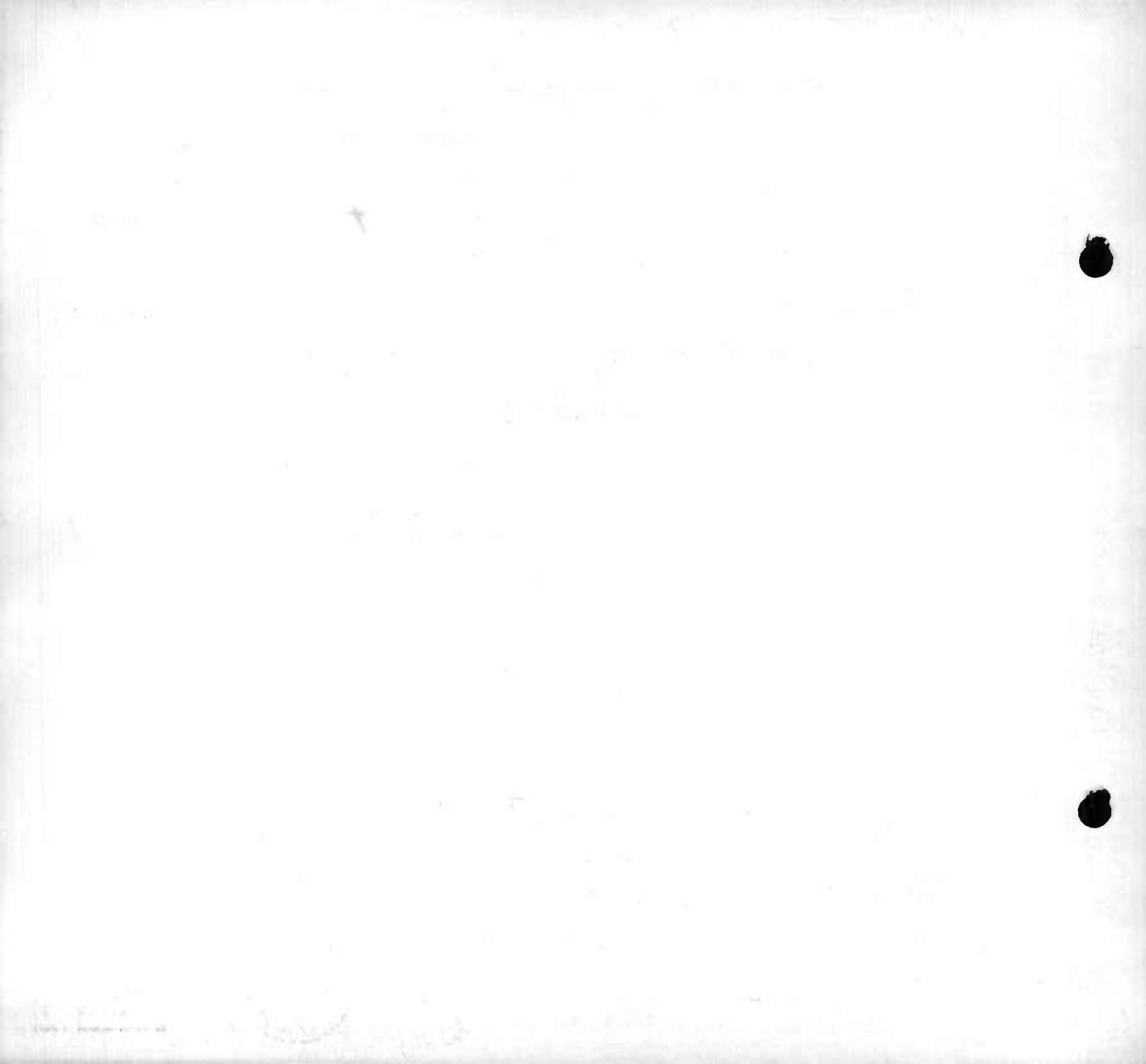
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>71 9096</b>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>COATES, JOSEPH FRANK</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>9/28/71 6:40 A.M.</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>23 Veterans Administration Hospital</b> <b>3900 L ch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> <b>5. CITY OR TOWN</b> <b>Lutherville</b> <b>6. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>7. STREET AND NUMBER</b> <b>627 W. SEMINARY AVE.</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>11/30/91</b>	<b>9. AGE</b> (In years last birthday) <b>79</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. G.O.</b>		
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>Dennis Coates</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Frances Booze</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 7/17/18 - 7/8/19</b>		<b>16. SOCIAL SECURITY NO.</b> <b>218-01-1439</b>		
<b>17. INFORMANT</b> <b>VA Hosp 3900 L ch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>		<b>ADDRESS</b>		
<b>18. CAUSE OF DEATH</b> <b>I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>15 min</b> <b>7 days</b> <b>4 days</b> <b>20 yrs</b>
<b>19A. DATE OF OPERATION</b> <b>9/10/71</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>CAUSE OF DEATH</b>		
<b>20A. AUTOPSY?</b> (Yes or No) <b>NO</b>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
<b>21F. HOW DID INJURY OCCUR?</b>				
<b>22. I certify that (I) (this hospital) attended the deceased from June 25th 1971 to September 28th 1971 that (I) (we) last saw the deceased alive on September 28th 1971 and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <b>Stephen Greenberg</b>		<b>23B. DATE SIGNED</b> <b>9/28/71</b>		
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>STEPHEN GREENBERG M.D.</b>		<b>23D. ADDRESS</b> <b>3900 L ch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>		
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>10/1/71</b>		
<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Graveside mem. pk.</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>Balto. Md.</b>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>SEP 30 1971</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Barber, M.D.</b>		
<b>25C. FUNERAL DIRECTOR</b> <b>Chapman Funeral Home - 1701 M. Cullod St.</b>		<b>ADDRESS</b> <b>Balto. Md.</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9097</u>	
<b>BIRTH NO.</b> <u>B-635 71 9097</u>		<b>1. NAME OF DECEASED</b> (Type or Print) <u>MARY BRITTINGHAM</u>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 MARYLAND GENERAL HOSPITAL</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>9-28-71 11:50 A.M.</u>  <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALT.</u> <b>C. CITY OR TOWN</b> <u>BALTIMORE</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>602 HATHERSLEIGH RD.</u>			
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>01-02-06</u>		<b>9. AGE</b> (In years last birthday) <u>65</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> 		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MD.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>John H O' Malley</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary E. Carneal</u>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>214-22-8776</u>		<b>17. INFORMANT</b> <u>ADMISSION RECORD</u> ADDRESS			
<b>18. CAUSE OF DEATH</b>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) <u>Cholangitis</u> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cholangitis with multiple hepatic abscesses</u> <u>biliary obstruction</u>					
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <u>2</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <u>YES</u>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <u>9-28-71</u> to <u>9-28-71</u> that (I) (we) last saw the deceased alive on <u>9-28-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>Michael Grasso M.D.</u>				<b>23B. DATE SIGNED</b> <u>9-28-71</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>MICHAEL GRASSO M.D.</u>				<b>23D. ADDRESS</b> <u>Orange General Hosp.</u>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>1 Oct 71</u>		<b>24C. NAME of CEMETERY or CREMATORY</b> <u>Druid Ridge Cem.</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Pikesville, Md</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>SEP 30 1971</u>			
<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Smith, M.D.</u>		<b>25C. FUNERAL DIRECTOR</b> ADDRESS <u>Bojarski Funeral Home Balto. Md.</u>			

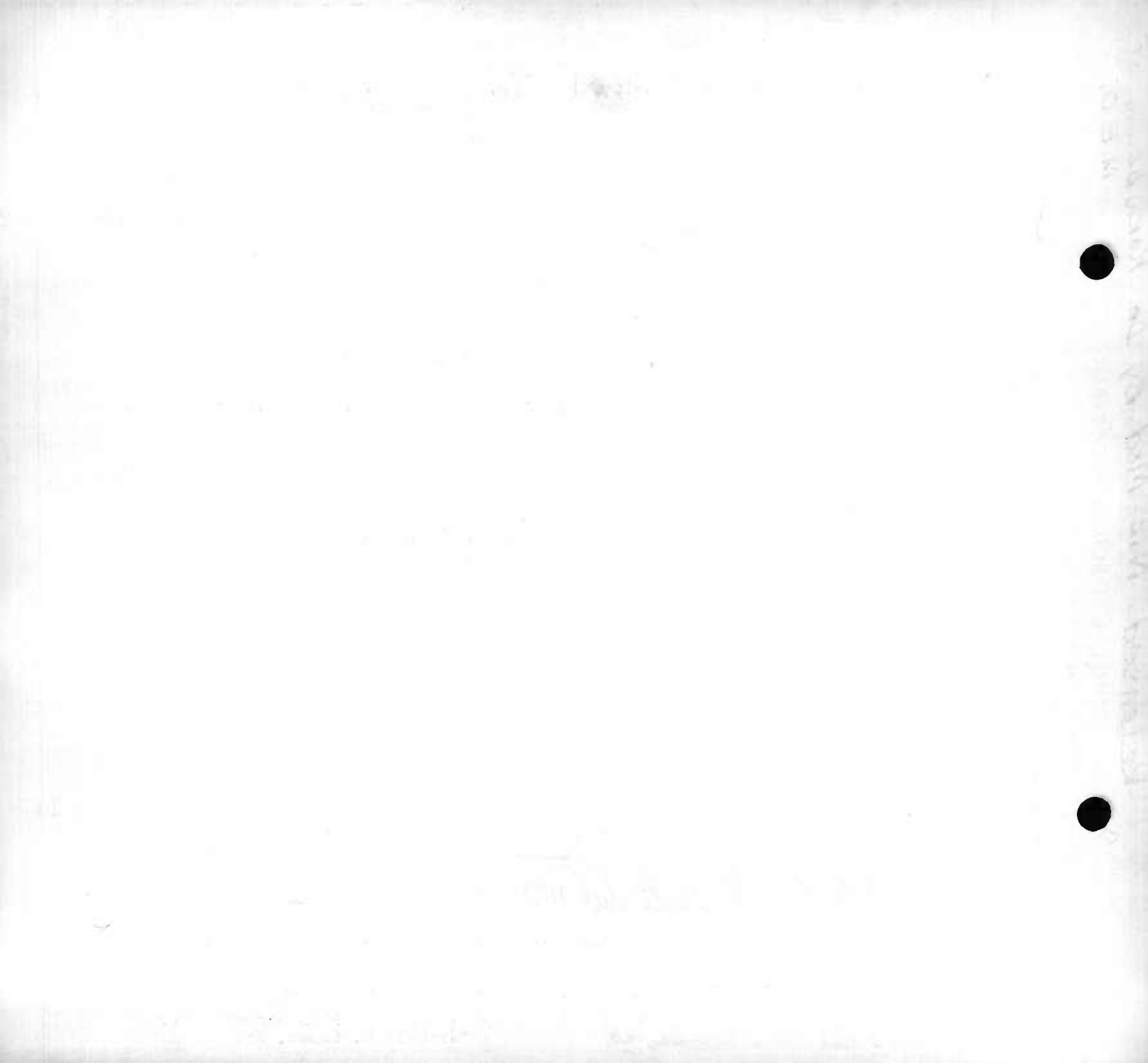




## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

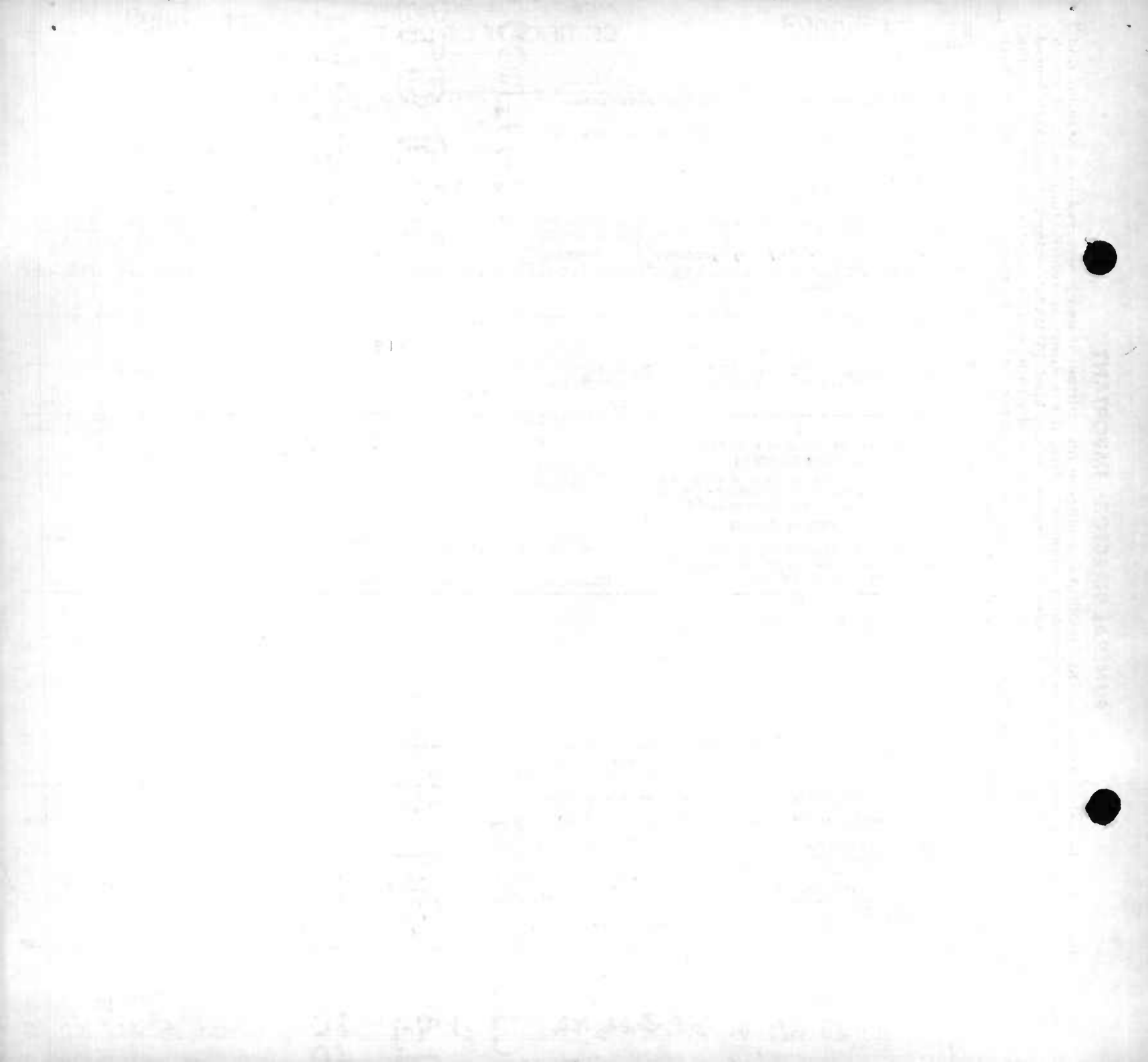
R-355 71 9098		BALTIMORE CITY HEALTH DEPARTMENT		71 9098	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) Alexander Redmond Jr.		2. DATE AND HOUR OF DEATH Sept 29th 1971 4 <sup>15</sup> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 807			
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1805 E Federal St					
5. SEX M	6. RACE B	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-22-16	9. AGE (In years last birthday) 55	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Sparrows Point		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME unk.		14. MOTHER'S MAIDEN NAME Arizona ?		17. INFORMANT Mrs. Arlean Redmond 1805 E. Federal St.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-05-5336		ADDRESS 21213	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE aspiration DUE TO, OR AS A CONSEQUENCE OF: (B) lung cancer DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hour	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Sept 29 1971 to Sept 29 1971 that (1) (we) last saw the deceased alive on Sept 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. DATA					
23A. SIGNATURE John C. Ruckdeschel, M.D.		23B. DATE SIGNED 9-29-71			
23C. PHYSICIAN'S NAME (Type) JOHN C. RUCKDESCHER, M.D.		23D. ADDRESS 1207 BORTON ST. BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-2-1971		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Pk., Inc. Baltimore, Maryland	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. SEP 30 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR 1735 Harford Ave. ADDRESS 21213 Marshall W. Jones, Jr.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				71 9099 W 452		71 9099	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		Williams, Freddie		9/28/71 1:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
33 Johns Hopkins Hospital				Baltimore			
				E. STREET AND NUMBER			
				1037 N. Chapel St			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. BIRTHPLACE (State or foreign country)	11. CITIZEN OF WHAT COUNTRY?	
M	N		11/24/11	59	GA.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN WILLIAMS				ANGIE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		428-07-6902		MILDRED L. WILLIAMS		1037 N. CHAPEL	
18. 431.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Introcranial Hemorrhage (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertension (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 hrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/27 1971 to 9/28 1971 that (I) <del>was</del> last saw the deceased alive on 9/28 1971 and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Louis E. Rambler MD				9/28/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
Louis E. Rambler MD		Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10-2-71		ARBUTUS MEM PR		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 30 1971		Robert E. Taylor, MD		Wm C. March		928 E. North Ave	



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHREG. NO. 71 9100BIRTH NO. W 2910

9100

1. NAME OF DECEASED  
(Type or Print)

Harold Frank Wise

2. DATE AND HOUR OF DEATH

9-26-71

6:10A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTIONIF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION31 Baltimore City Hospitals  
4940 Eastern Ave.  
Baltimore, Md. 212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2822 Harlem Ave. 21216

5. SEX

Male

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

2-26-13

9. AGE (In years  
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William A. Wise

14. MOTHER'S MAIDEN NAME

Agnes Wise Hall

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

215-10-7064

17. INFORMANT

BCH Records: 4940 Eastern Ave.  
Baltimore, Md. 21224

ADDRESS

18. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

Cirrhosis of Liver

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY i.e., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/24 1971 to 9/26 1971  
that (I) (we) last saw the deceased alive on 9/26 1971 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S  
NAME (Type)

23D. ADDRESS

DEGREE

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

9-30-71

Mt Auburn Cemetery

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

SEP 30 1971

Robert E. Farber, M.D.

Wm O March

928 E. North Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Burial 9-30-71 Mt Auburn Cemetery Balto., Md.  
Wm C March 928 E. North Ave.

Yes

Yes

218-10-7064

William A. Wise

Admes Wise Hall

3100

3100

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-500

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 71 9101

BIRTH NO. 71 9101		2. DATE AND HOUR OF DEATH 9-29-71 2:35 P.M.	
1. NAME OF DECEASED (Type or Print) MAHONEY WILLIAM H.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY 339 S. Small - Md. Baltimore	
5. SEX Male		6. RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 22, 1899 72	
9. AGE (In years last birthday) 72		10. CITIZEN OF WHAT COUNTRY? U.S.A	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 216-01-2037	
17. INFORMANT Margaret T. Mahoney, Wife - 810 Wellington St.		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) 0		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 9-19-1971 to 9-29-1971 that (I) (we) last saw the deceased alive on 9-29-1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Jason Samuel		23B. DATE SIGNED 9-29-71	
23C. PHYSICIAN'S NAME (Type) JASON SAMUEL		23D. ADDRESS Lutheran Hospital of Maryland 730, Ashmont St, Baltimore MD-21216	
24A. BURIAL CREMATION, REMOVAL (Specify) 0		24B. DATE 9/30/71	
24C. NAME OF CEMETERY or CREMATORY St. Alphonsus Cem		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 30 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	

V.S. 153

10-13-71

M.H.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9102</u>	
BIRTH NO. <u>71 9102</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>KATIE C. BUTLER Gould</u>			2. DATE AND HOUR OF DEATH <u>12 NOON</u> <u>19/27/1971</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>BON'S SECOURS Hospital</u> <u>Baltimore + Pulaski Sts.</u> <u>Baltimore, MARYLAND</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>2004</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>2261 West Baltimore St</u>					
5. SEX <u>FEMALE</u>	6. RACE <u>BLACK</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/28/98</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ERNEST BUTLER</u>		14. MOTHER'S MAIDEN NAME <u>Shara J. Bush</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-22-6963A</u>		17. INFORMANT <u>Marie Butler</u> <u>2022 N. Pulaski St.</u>	
18. <u>540.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Lower nephron nephrosis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Prolonged septic shock (endotoxic)</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Perforated appendicitis with fistula formation. Resection of cecum.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>weeks</u> <u>months</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>9-10-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Fistula of small intestine</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>July 5, 1971</u> 19__ to <u>Sept 27</u> 19__ that (1) (we) last saw the deceased alive on <u>Sept 27</u> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Vilvaivan Thitivarana, M.D.</u> DEGREE				23B. DATE SIGNED <u>Sept 27, 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>VILVAIVAN THITIVARANA, M.D.</u> DEGREE				23D. ADDRESS <u>BON SECOURS HOSPITAL, BALT, Md. 21223</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10-1-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	
24D. LOCATION <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 30 1971</u>		25B. NAME OF REGISTRAR <u>Valerie E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Charles A. Rice</u> ADDRESS <u>661 W. Barre St.</u>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

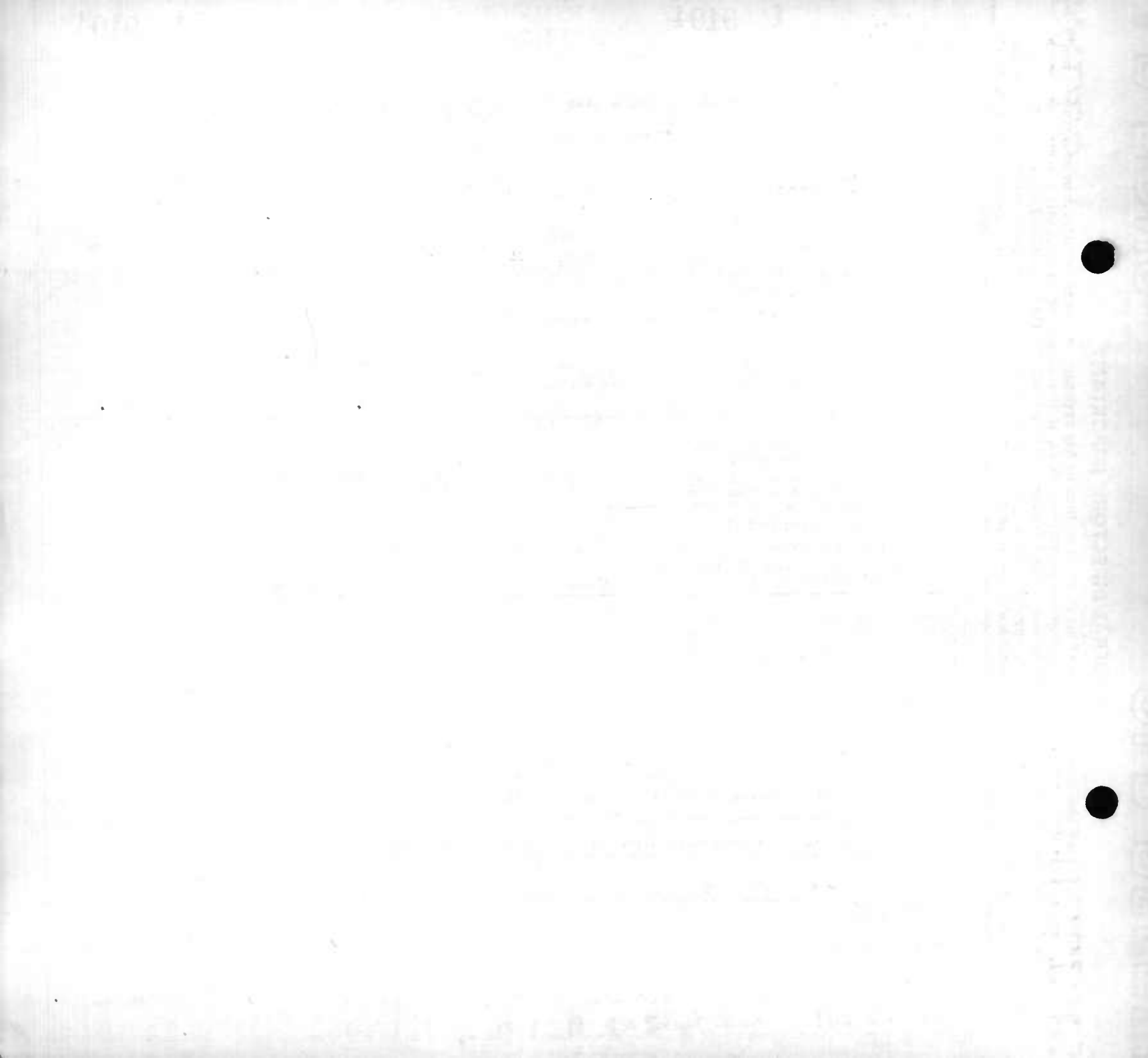
1. NAME OF DECEASED (Type or Print) <b>Dwight Robert Dodd or Dewight Robert Dodd</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 9 28 71 1:06 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF DECEASED (Type or Print) <b>10-18-71</b> ADDRESS OR LOCATION <b>Alley in rear of 2700 Harford Rd.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 28 71 1:06 A. M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>906</b>	
9. DATE OF BIRTH <b>8.17.49</b>		10. AGE (In years lost birthday) <b>22</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <b>Goldie Washignton</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1967 to 1969</b>		17. SOCIAL SECURITY NO. <b>217-52-5971</b>	
18. INFORMANT <b>Goldie Washington</b>		ADDRESS <b>4305 Mainfield Av.</b>	
19. <b>E 983X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Hanging</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Alley</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>9 26 71 12.58 pm</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>rear of 2700 Harford Road</b>		22F. HOW DID INJURY OCCUR? <b>Hung self - Motive unknown</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10.2.71</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 30 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>661 W. Barre St.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">71 9104</span>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">71 9104</span>	
1. NAME OF DECEASED (Type or Print) <i>Stump Joseph</i>				2. DATE AND HOUR OF DEATH <i>9-28-71</i> <i>2<sup>30</sup></i> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <i>Maryland</i>		B. COUNTY <i>2301</i>	
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>1246-48-50 S. Sharp St</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Aug-7-1914</i>	9. AGE (in years last birthday) <i>57</i>	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sell - Employed Stump's Bar &amp; Restaurant</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John R. Stump</i>				14. MOTHER'S MAIDEN NAME <i>Emma P. Long</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes WW 2</i>		16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT <i>Charlotte M. Wagner</i>		ADDRESS <i>709 Bartlett Ave.</i>	
18. <i>486X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Anoxia</i> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Extensive Pneumonia</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>9-24</i> 19 <i>71</i> to <i>9-28</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>9-28</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>D. C. Scrongon</i>				23B. DATE SIGNED <i>9-28-71</i>		23C. PHYSICIAN'S NAME (Type) <i>D. C. Scrongon</i>	
23D. ADDRESS <i>South Baltimore, General Hospital</i>				23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>10/2/71</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Cross Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Glen Burnie, Anne Arundel, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 30 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. J. J. J.</i>		25C. FUNERAL DIRECTOR <i>McClary Funeral Home</i>			
				ADDRESS <i>130 E. Fort Avenue</i>			



1

5-30071 9105 BALTIMORE CITY HEALTH DEPARTMENT

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. REG. NO. 71 9105

1. NAME OF DECEASED (Type or Print) George Scott		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 24 Year 71 Hour 12:55 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital		3. DATE PRONOUNCED DEAD Month 9 Day 24 Year 71 Hour 12:55 p.m.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Knoxville	
9. DATE OF BIRTH 5-24-1924		10. AGE (in years lost birth day) 43 47	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Otho W. Scott		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.C. Summers Milling	
15. MOTHER'S MAIDEN NAME Katie Louise Weedon		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Winfield T. Scott- Brunswick, Md.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HIGHWAY		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rt. 75 - Frederick, Md. 6000	
22D. TIME OF INJURY (APPROX.) 9 5 71 7:30 p.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Subject was passenger in one car accident.		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Liskovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 9/25/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-29-71	
24C. NAME OF CEMETERY or CREMATORY AME Church		24D. LOCATION (City, town, or county) (State) Peterville md	
25A. DATE REC'D BY HEALTH DEPT SEP 30 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	

VS 151-REV. 1/1/68

N 869.0

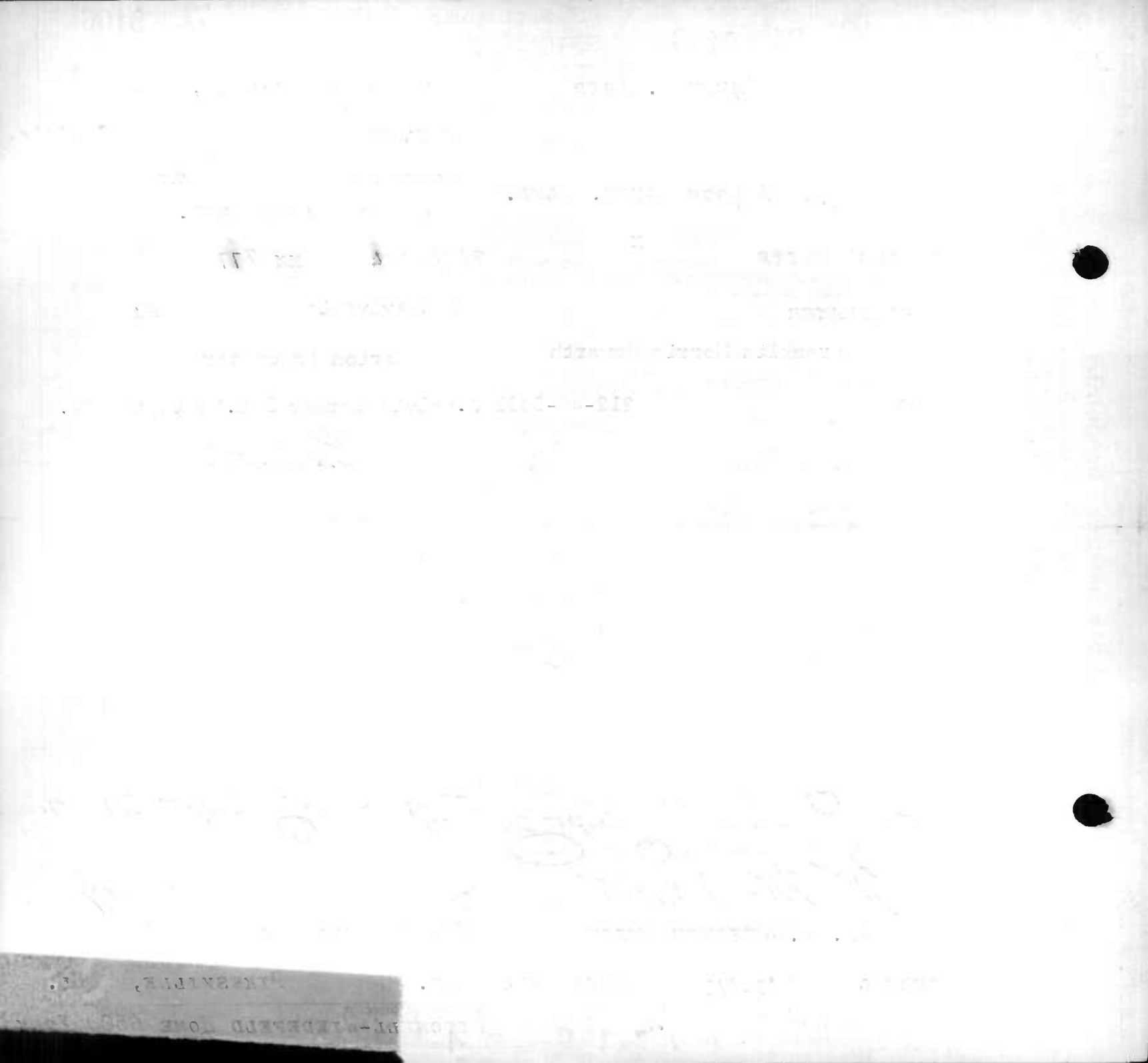
Bank 9-29-71 AME Church  
Petersonville  
The Foundation Bank



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 9106	
CERTIFICATE OF DEATH				REG. NO. _____	
BIRTH NO. <u>L-100</u>		71 9106			
1. NAME OF DECEASED (Type or Print) <u>IRENE H. LAIB</u>			2. DATE AND HOUR OF DEATH <u>SEPTEMBER 27, 1971</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2739</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> <u>4804 LOCH RAVEN. BLVD.</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>4804 LOCH RAVEN BLVD.</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/6/1894</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Franklin Morris Howarth</u>			14. MOTHER'S MAIDEN NAME <u>Marion Lancaster</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-46-5051</u>		17. INFORMANT ADDRESS <u>J. Calvin Carney 3 E. Lexington ST.</u>	
18. <u>410.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>MYOCARDIAL INFARCTION</u> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>JULY 25 1965</u> to <u>SEPT 27 1971</u> that (1) (we) last saw the deceased alive on <u>SEPT 24 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W. M. Smith</u>				23B. DATE SIGNED <u>9/27/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. W. MERIDETH SMITH</u>				23D. ADDRESS <u>6305 THE ALAMEDA</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9/29/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE CEM.</u>	
24D. LOCATION (City, town, or county) (State) <u>PIKESVILLE, MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 30 1971</u>		25B. NAME OF REGISTRAR <u>Robert J. ...</u>		25C. FUNERAL DIRECTOR ADDRESS <u>MITCHELL-WIEDEFELD HOME 6500 YORK</u>	



71 9107

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

**BIRTH NO.** \_\_\_\_\_

<b>1. NAME OF DECEASED</b> (Type or Print) <u>Robert Thorne</u>		<b>2. DATE OF DEATH</b> Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <u>9</u> <u>25</u> <u>71</u> <u>9:35 a.</u> M.	
<b>4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u>		<b>3. DATE PRONOUNCED DEAD</b> Month Day Year Hour <u>9</u> <u>25</u> <u>71</u> <u>9:35 a.</u> M.	
<b>5. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Prince Georges</u>			
<b>6. SEX</b> <u>male</u>	<b>7. RACE</b> <u>White</u>	<b>8. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>C. CITY OR TOWN</b> <u>Oxon Hill</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>9. DATE OF BIRTH</b> <u>2/16/1914</u>		<b>10. AGE</b> (In years lost birthday) <u>57</u> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Washington, D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>14. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Machine Opr. (Mail Room)</u>		<b>15. MOTHER'S MAIDEN NAME</b> <u>Marie Minor</u>	
<b>16. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		<b>17. SOCIAL SECURITY NO.</b> <u>577-22-6950</u>	
<b>18. INFORMANT</b> <u>Edith Thorne, Wife; Same as #5</u> <b>ADDRESS</b>			

**19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**  
 (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  
E 812.0  
**ANTECEDENT CAUSES**  
 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
 II  
 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

**CAUSE OF DEATH**  
Multiple injuries  
**(A) IMMEDIATE CAUSE**  
 DUE TO, OR AS A CONSEQUENCE OF:  
**(B)** \_\_\_\_\_  
 DUE TO, OR AS A CONSEQUENCE OF:  
**(C)** \_\_\_\_\_

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

<b>20A. DATE OF OPERATION</b> <u>2</u>	<b>20B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>	<b>21. AUTOPSY?</b> (Yes or No) <u>yes</u>
<b>22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>	<b>22B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>HIGHWAY</u>	<b>22C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <u>Rt. 495 &amp; 450 -Prince George Ct.</u>
<b>22D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour) (Min.) <u>9</u> <u>25</u> <u>71</u> <u>7:15</u> a. m.	<b>22E. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	<b>22F. HOW DID INJURY OCCUR?</b> <u>Subject was driver in car-truck accident</u>

**23.**

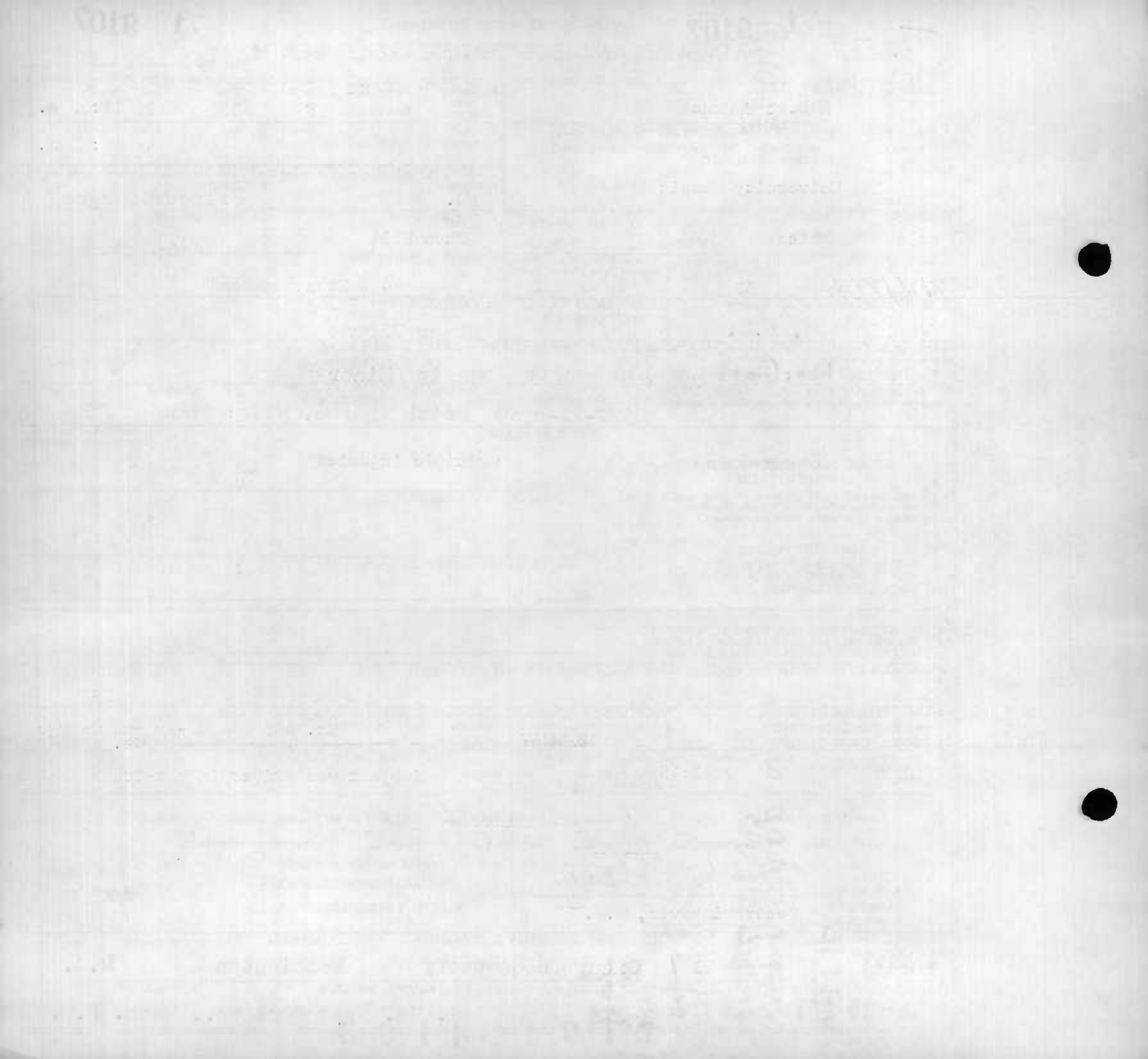
I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

**ACTUAL SIGNATURE**  
Peter Lipkovic  
**EXAMINER'S NAME (Type)** Peter Lipkovic, M.D.

**CHIEF MEDICAL EXAMINER** ☐  
**ASSISTANT MEDICAL EXAMINER** ☒  
**ASSOCIATE MEDICAL EXAMINER** ☐  
**DATE SIGNED**  
9/25/71

<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>24B. DATE</b> <u>9/29/71</u>	<b>24C. NAME of CEMETERY or CREMATORY</b> <u>Glenwood Cemetery</u>	<b>24D. LOCATION</b> (City, town, or county) (State) <u>Washington D.C.</u>
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>SEP 30 1971</u>	<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Farber, M.D.</u>	<b>25C. FUNERAL DIRECTOR</b> <u>J. Wm. Lees Sons Co., Wash. D.C.</u> <b>ADDRESS</b>	

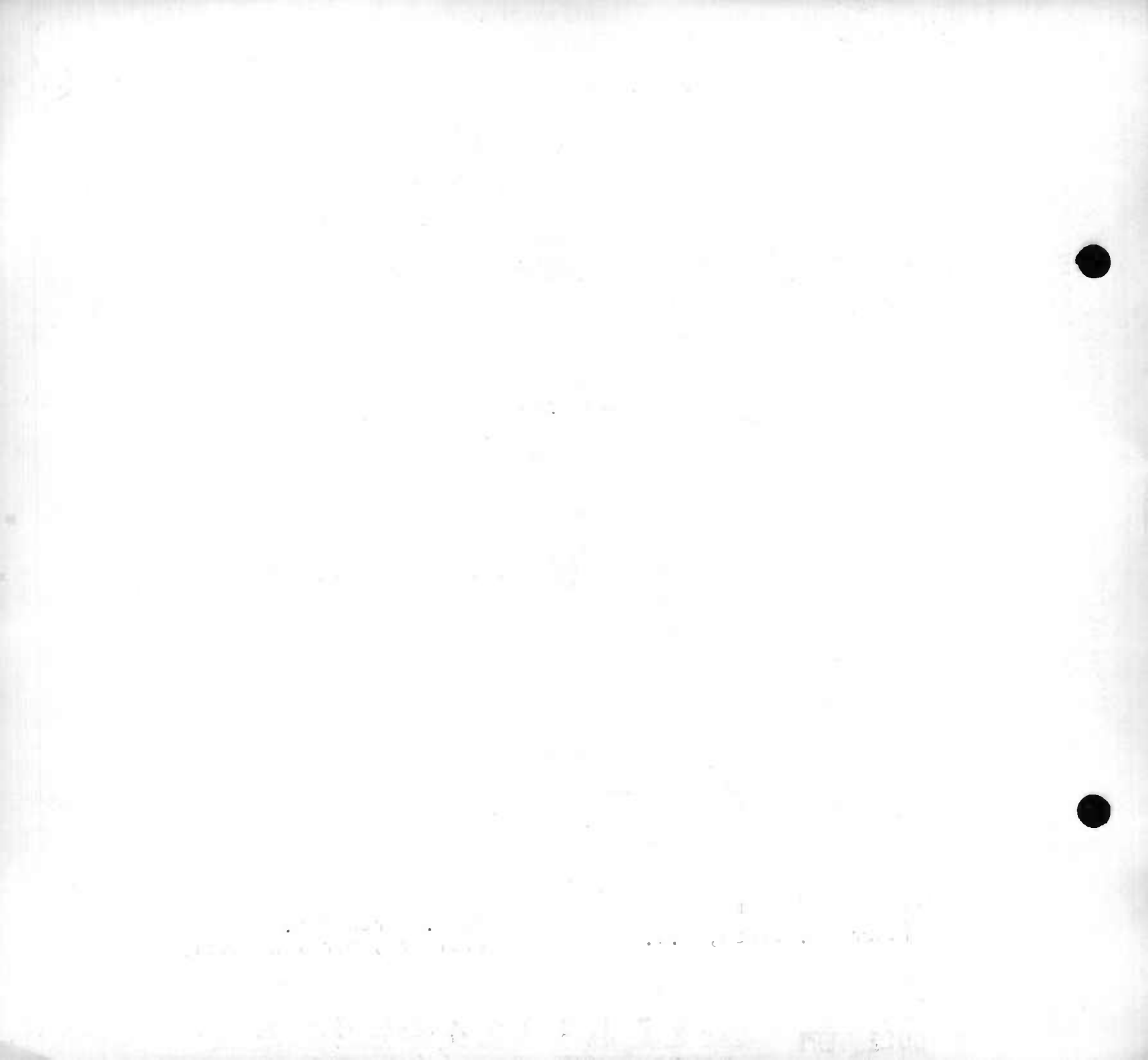
VS 151-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 9108
CERTIFICATE OF DEATH				REG. NO. _____
H-520 71 9108				
1. NAME OF DECEASED (Type or Print) <b>Katie Haines</b>		2. DATE AND HOUR OF DEATH <b>9/26/71 6:55 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>5700</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>George Washington Nursing Home</b> <b>607 Pennsylvania Ave.</b>		C. CITY OR TOWN <b>Conowingo</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER <b>Mt. Zora Rd.</b>				
5. SEX <b>Female</b>	6. RACE <b>N W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5/8/74</b>	9. AGE (In years last birthday) <b>97</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Joseph Haines</b>		14. MOTHER'S MAIDEN NAME <b>Barnes</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-523469</b>		17. INFORMANT <b>Chent</b> ADDRESS <b>607 Pennsylvania Ave</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>412.2 I</b> <b>HYPERTENSIVE ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>DEGENERATIVE OSTEOARTHRITIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YRS.</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>DEGENERATIVE OSTEOARTHRITIS</b>		<b>YRS.</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <b>4-30-1969</b> to <b>9-26-1971</b> that (1) (we) last saw the deceased alive on <b>9-26-1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Richard F. Tyson, M.D.</b>		23B. ADDRESS <b>938 N. North Ave. Baltimore, Maryland 21217</b>		23C. DATE SIGNED <b>9-26-71</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/30/71</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>				
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>John C. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR <b>Adolphus H. Heston</b> ADDRESS <b>1206 W North Ave</b>



1. NAME OF DECEASED (Type or Print) <b>FRANK KEMBLE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF DECEASED (NOT A HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 8 E. Preston St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 26 1971 11:40 P.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1102</b>			
6. SEX <b>male</b>	7. RACE <b>white</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>10/23/00</b>		10. AGE (In years last birthday) <b>70</b>	
11. BIRTHPLACE (State or foreign country) <b>New York N Y</b>		12. CITIZEN OF <b>WHAT COUNTRY?</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>	
15. MOTHER'S MAIDEN NAME <b>JANICE</b>		13. FATHER'S NAME <b>EDMUND KEMBLE</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		17. SOCIAL SECURITY NO. <b>430-07-7354</b>	
18. INFORMANT <b>Mrs Janice Firden</b>		ADDRESS <b>15800 Lindsay St Detroit MI</b>	
19. <b>146.0</b>		CAUSE OF DEATH <b>Cancer of tonsils</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>9-27-71</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>	24B. DATE <b>10/1/71</b>	24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Frederick B. Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 1 1971</b>		25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>	25C. FUNERAL DIRECTOR ADDRESS <b>1206 W north Ave</b>

Letter from M. E. to office  
10-1-71 M. H.

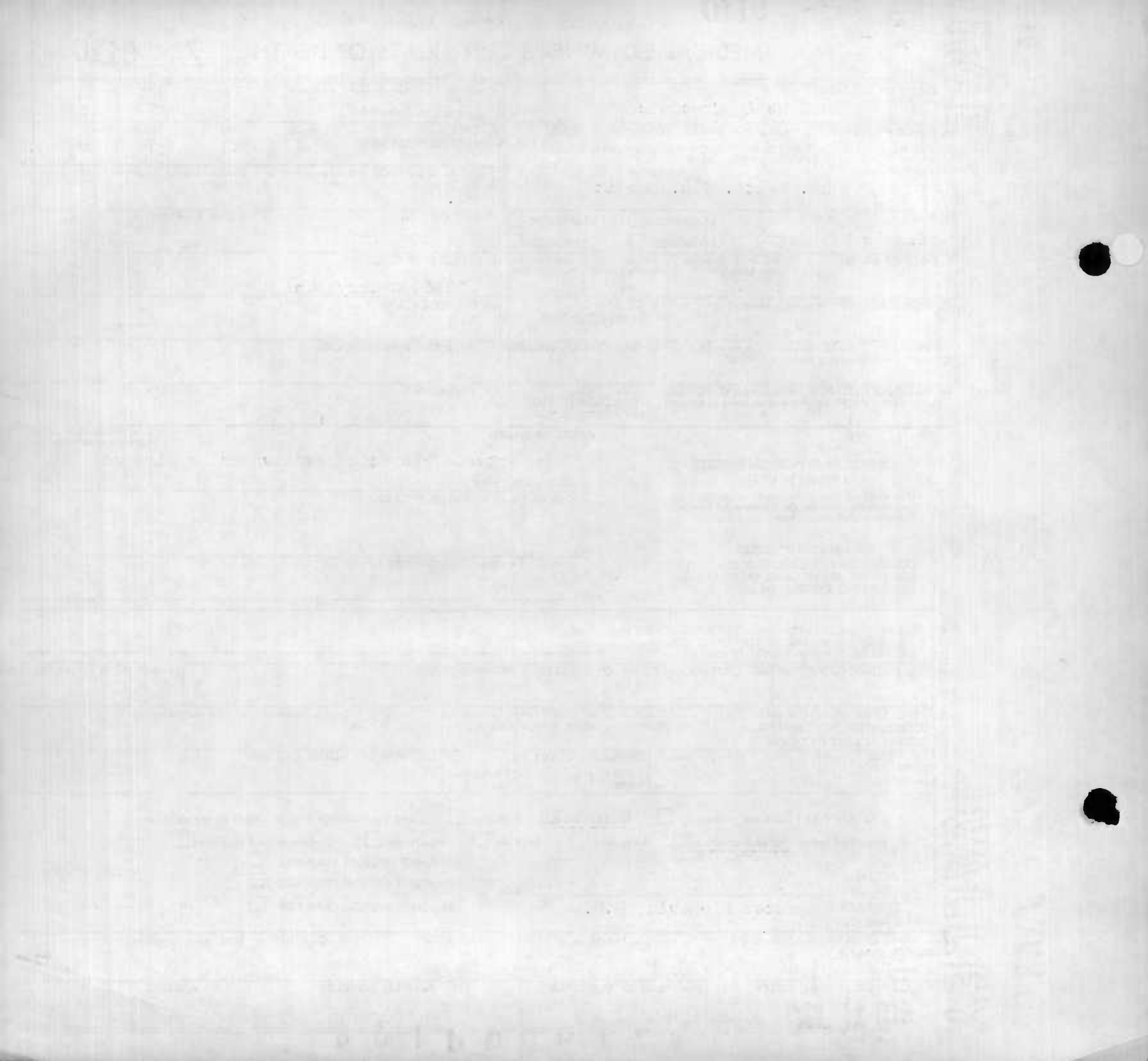


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9110

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ophelia Truedale		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 24 Year 71 Hour 6:00 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION So. Balto. Gen. Hospital		3. DATE PRONOUNCED DEAD Month 9 Day 24 Year 71 Hour 6:00 p.m.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 5300		6. SEX female 7. RACE Negro 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. DATE OF BIRTH 10. AGE (In years last birthday) 78 11. BIRTHPLACE (State or foreign country) South Carolina 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 14B. KIND OF BUSINESS OR INDUSTRY 15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 215-01-8522 18. INFORMANT Mrs Stukes, 800 Bridgeview Road ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/25/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/30/71 24C. NAME of CEMETERY or CREMATORY MT Calvary Cemetery 24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. OCT 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9111</u>	
J-520 71 9111				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>JAMES MELVIN</u>		2. DATE AND HOUR OF DEATH <u>9-24-71</u> <u>1:55</u> A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1606</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <u>11-04-12</u>		9. AGE (In years last birthday) <u>58</u>		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Constant B James</u>		14. MOTHER'S MAIDEN NAME <u>Mae V Laird</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chart</u> ADDRESS	
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute M.I.</u>		<u>1 day</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Acute M.I.</u>		<u>1 day</u>	
		(C) <u>Acute M.I.</u>		<u>1 day</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>9-23-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>9-23-1971</u> to <u>9-24-1971</u> that (I) (we) last saw the deceased alive on <u>9-24-1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		M.D. DEGREE <u>[Signature]</u> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9-24-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>JASON SAMUEL</u>		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/1/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt Calvary Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>A A County Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 1 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u> ADDRESS <u>1206 W north A</u>			

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NY

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Mae V Laird

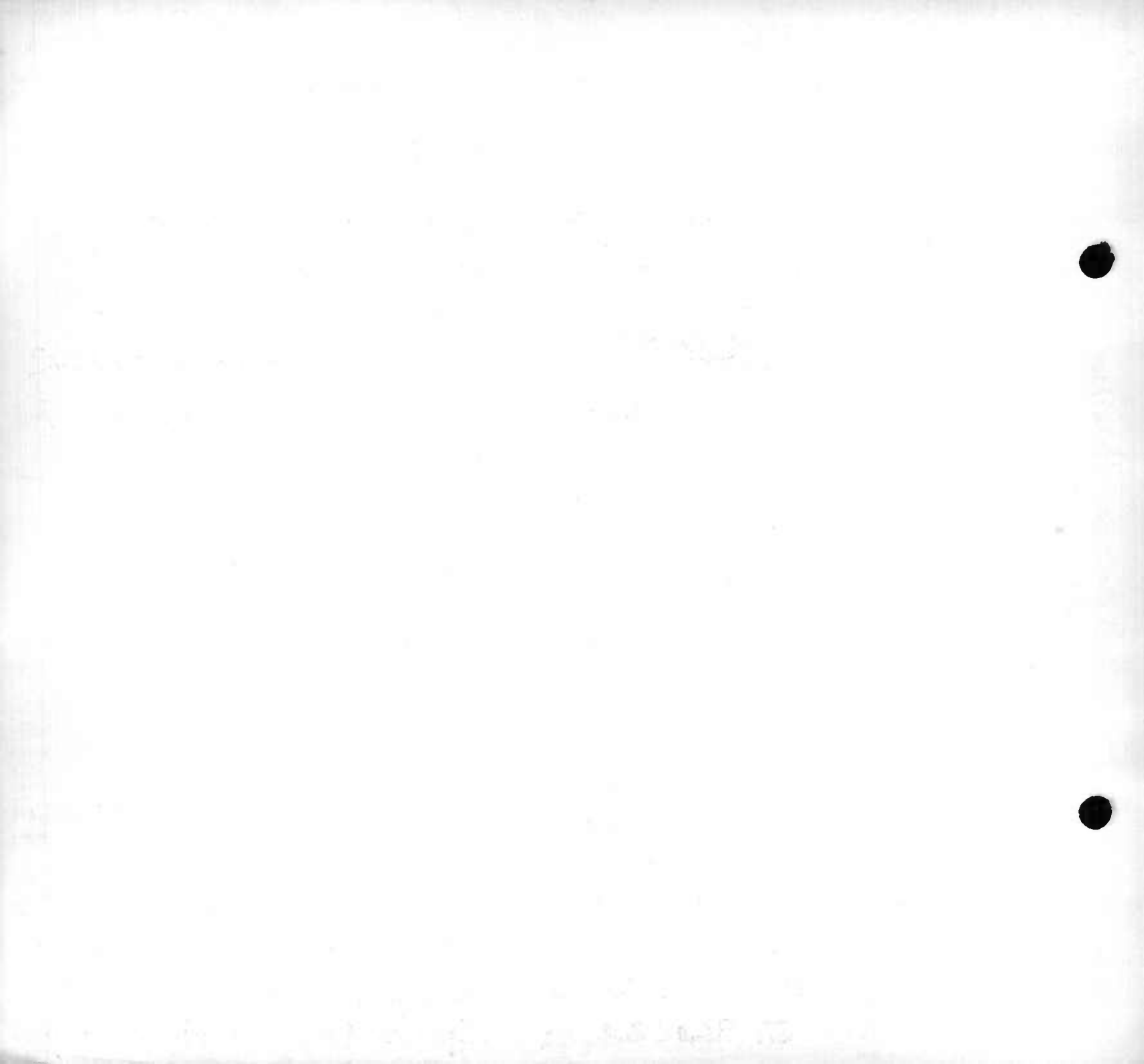
Constant B James

Laborer

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 9112	
71 9112				71 9112	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SALLIE BATTIS</b>		2. DATE AND HOUR OF DEATH <b>SEPT 28, 1971</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <b>PRENSEN NURSING HOME</b> <b>2922 Trunah Ave.</b>		A. STATE <b>MARYLAND</b>		<b>1537</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>3116 LIEDMONT AVE</b>			
5. SEX <b>F</b>	6. RACE <b>C.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 27-1888</b>	9. AGE (in years last birthday) <b>79</b>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>STONEY CREEK VA. USA</b>	
13. FATHER'S NAME <b>John W. HARVEY</b>		14. MOTHER'S MAIDEN NAME <b>SALLIE HARVEY GARNER</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-208728</b>		17. INFORMANT <b>MARY C COUSIN</b>	
		ADDRESS <b>316 LIEDMONT AVE</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>4/12/21</b>		CAUSE OF DEATH <b>Cardio-Vascular Disease.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b>			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Hypertension</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 21, 1971</b> to <b>Sept. 28, 1971</b> that (I) (we) last saw the deceased alive on <b>Sept. 28, 1971</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Frank N. Ogden, M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Sept. 30, 1971</b>	
23C. PHYSICIAN'S NAME (Type) <b>FRANK N. OGDEN, M.D.</b>		23D. ADDRESS <b>2701 N. Calvert St Baltimore, Md. 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>OCT 2, 1971</b>	24C. NAME OF CEMETERY or CREMATORY <b>MT AUBURN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 1 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>V. Brooks Ringgold</b>	
		ADDRESS <b>1463 N. CAREY ST</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
71 9113					71 9113					
R-263					CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>BYRON W. RICHARDS</b>					2. DATE AND HOUR OF DEATH <b>9-30-71 12 21 A.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL</b> <b>44</b>					4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4217 DARNALL ROAD</b>					
5. SEX <b>M</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-15-89</b>	9. AGE (In years last birthday) <b>82</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Wholesale Liquor</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JAMES RICHARDS</b>			14. MOTHER'S MAIDEN NAME <b>ALICE WILSON</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>215-03-4145</b>		17. INFORMANT <b>Mrs. Dorothy Richards same</b>				ADDRESS	
18. <b>250.7 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CORONARY OCCLUSION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>advanced A.S. CVD.</b> <b>DIABETES MELLITUS</b> <b>ANEMIA &amp; HEEL ULCERS.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>9-23 1971</b> to <b>9-30 1971</b> that (II) (we) last saw the deceased alive on <b>9-29 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>A. J. Helou, M.D.</b>					23B. DATE SIGNED <b>9-30-71</b>			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		
23C. PHYSICIAN'S NAME (Type) <b>A. J. HELOU, M.D.</b>					23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)			
<b>Burial</b>		<b>10/2/71</b>		<b>Druid Ridge</b>			<b>Balto. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 1 1971</b>			25B. NAME OF REGISTRAR <b>Robert E. [unclear]</b>			25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>				

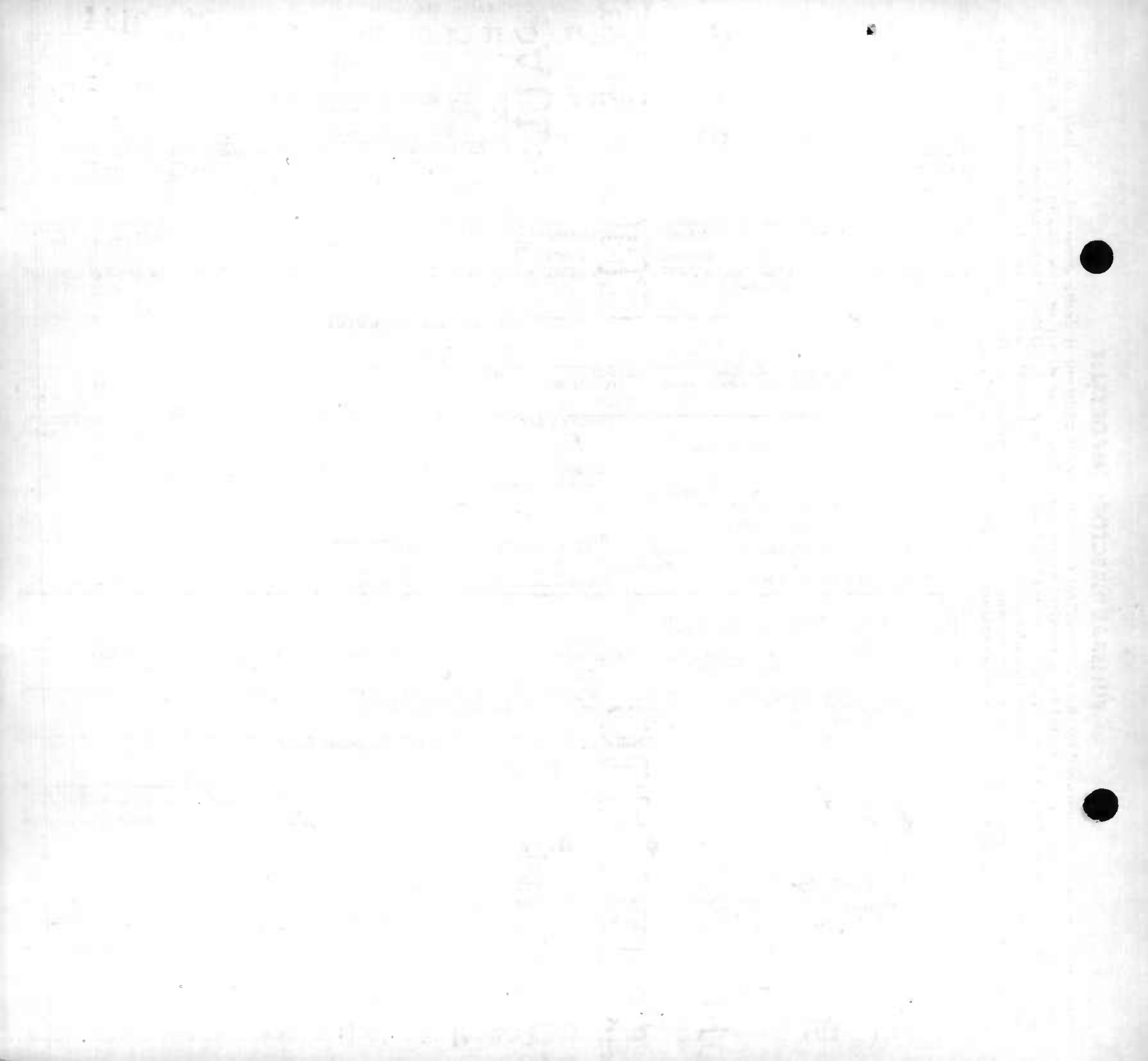




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 9114	
BIRTH NO. <b>L-300 71 9114</b>				1. NAME OF DECEASED (Type or Print) <b>LueTTe, Ann Marie</b>		2. DATE AND HOUR OF DEATH <b>9-28-71 2:30 p.m. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Idaho</b> B. COUNTY <b>VIO</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Lewiston, Idaho</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Fe</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-21-57</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) <b>13</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Donald J. Luetete</b>				14. MOTHER'S MAIDEN NAME <b>Marian E Doyle</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Donald J Luetete 906 Grelle Ave Idaho</b>			
18. <b>170.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Insufficiency</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>metastases</b> <b>osteogenic sarcoma</b>				CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>9-28-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>osteogenic sarcoma</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>7-1-71</b> 19 to <b>9-28-71</b> 19 that (I) (we) last saw the deceased alive on <b>9-28-71</b> 19 and that (I) (we) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Jose B. Corvera, M.D.</b>				23B. DATE SIGNED <b>9-28-71</b>		23C. PHYSICIAN'S NAME (Type) <b>JOSE B. CORVERA</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-1-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lake View Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Eldersberg, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 1 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J Buck Inc.</b>		ADDRESS <b>Balto., Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

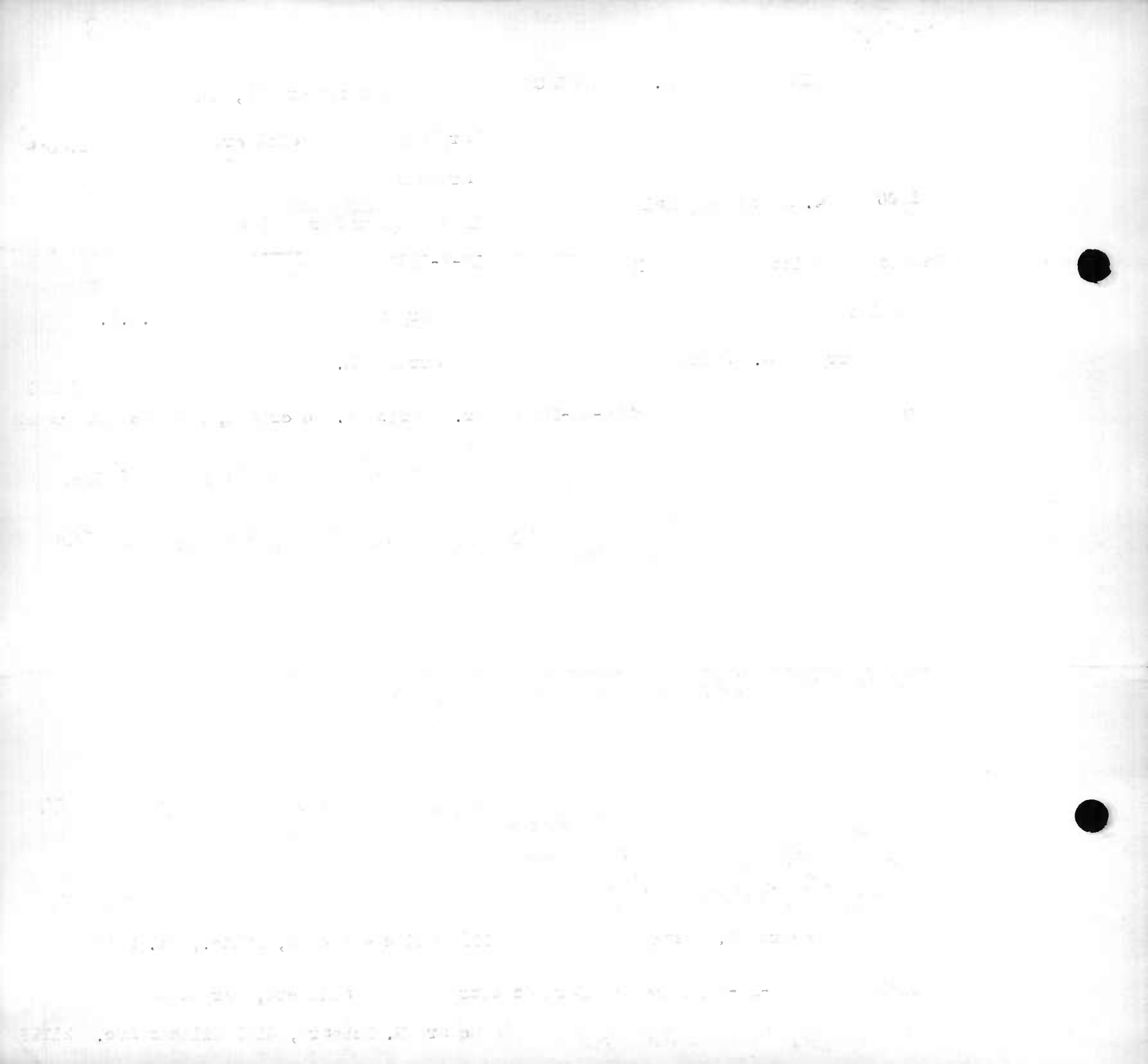
BALTIMORE CITY HEALTH DEPARTMENT				71 9115	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. 71 9115		2. DATE AND HOUR OF DEATH Sept 29 1971 6:57 A.M.			
1. NAME OF DECEASED (Type or Print) Holehan, Isabel W.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE Maryland B. COUNTY 2102		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female 6. RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03/11/14 9. AGE (In years last birthday) 57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maryland Cup Co.		10B. KIND OF BUSINESS OR INDUSTRY Baker		11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Jenkins		14. MOTHER'S MAIDEN NAME Lena Goff		15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) no 16. SOCIAL SECURITY NO. -	
17. INFORMANT Mr Francis Holehan		ADDRESS above		18. 410.9 I CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiogenic Shock		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(B) DUE TO, OR AS A CONSEQUENCE OF: Acute MI		6 hr	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 29 19 71 to 19 71 that (I) (we) last saw the deceased alive on Sept 29 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lawrence Giles		23B. DATE SIGNED 9/29/71		23C. PHYSICIAN'S NAME (Type) DEGREE	
23D. ADDRESS		23E. ADDRESS		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/2/71		24C. NAME OF CEMETERY or CREMATORY New Cathedral Ave.	
24D. LOCATION Baltimore		24E. LOCATION Baltimore		24F. LOCATION Baltimore	
25A. DATE REC'D BY HEALTH DEPT. OCT 1 1971		25B. NAME OF REGISTRAR Robert E. Gable, M.D.		25C. FUNERAL DIRECTOR 901 N. Charles St. 21223	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9116</u>
S-564 71 9116				
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) <b>HILDA E. SOMERLOCK</b>		2. DATE AND HOUR OF DEATH <b>September 27, 1971</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 St. Agnes Hospital</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
		C. CITY OR TOWN <b>Arbutus</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER <b>1546 Sulphur Spring Road</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-9-1909</b>	9. AGE (In years last birthday) <b>61</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Harry E. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Carrie L. Stange</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-46-3230</b>		17. INFORMANT <b>Mr. Charles R. Somerlock, 5070 Bonnie Branch</b>
18. <b>200.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>INTRA AORTIC Atherosclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>RETICULUM CILI SACCOLA STOMACH</b> DUE TO, OR AS A CONSEQUENCE OF: <b>3 YRS</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>12/16/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>SARCOMA - STOMACH</b>		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>12/16</b> 19 <b>69</b> to <b>9/27</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>9/27</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Robert F. Healy M.D.</b>				23B. DATE SIGNED <b>9/28/71</b>
23C. PHYSICIAN'S NAME (Type) <b>Robert F. Healy</b>				23D. ADDRESS <b>3350 Wilkens Avenue, Balto., Md. 21229</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-30-1971</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 1 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>
				ADDRESS <b>4107 Wilkens Ave. 21229</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9117</u>
BIRTH NO. <u>R-162 71 9117</u>		1. NAME OF DECEASED (Type or Print) <u>DR. GEORGE E. REHBERGER</u>		
2. DATE AND HOUR OF DEATH <u>September 28, 1971</u>		M. <u>1348</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> HOSPITAL OR INSTITUTION <u>10-5-71</u> ADDRESS OR LOCATION <u>5808 N. Charles Street</u>		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
5. SEX <u>Male</u>		6. RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>Nov. 25, 1880</u>		9. AGE (In years last birthday) <u>90</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>John Henry Rehburger</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jane Everett</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WW1 &amp; Spanish-Amer.</u>		16. SOCIAL SECURITY NO. <u>220-44-1677</u>		17. INFORMANT <u>Rehburger</u> ADDRESS <u>Dr. John M. Rehburger 5808 N. Charles St.</u>
18. <u>440.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE Cardiac Failure</u> <u>(B) Generalized arteriosclerosis</u> <u>(C) old age</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>February 1965</u> to <u>September 1971</u> that (I) (we) last saw the deceased alive on <u>Sept 28 1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>John M. Rehburger MD</u> DEGREE <u>M.D.</u>				23B. DATE SIGNED <u>9-28-71</u>
23C. PHYSICIAN'S NAME (Type) <u>John M. Rehburger</u>		23D. ADDRESS <u>5808 N. Charles Street</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-1-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. John's Church Cemetery</u>
24D. LOCATION (City, town, or county) <u>Long Green</u>		(State) <u>Balt. Co. Md</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 1 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Inc</u> ADDRESS <u>1050 York Rd Towson, Maryland</u>

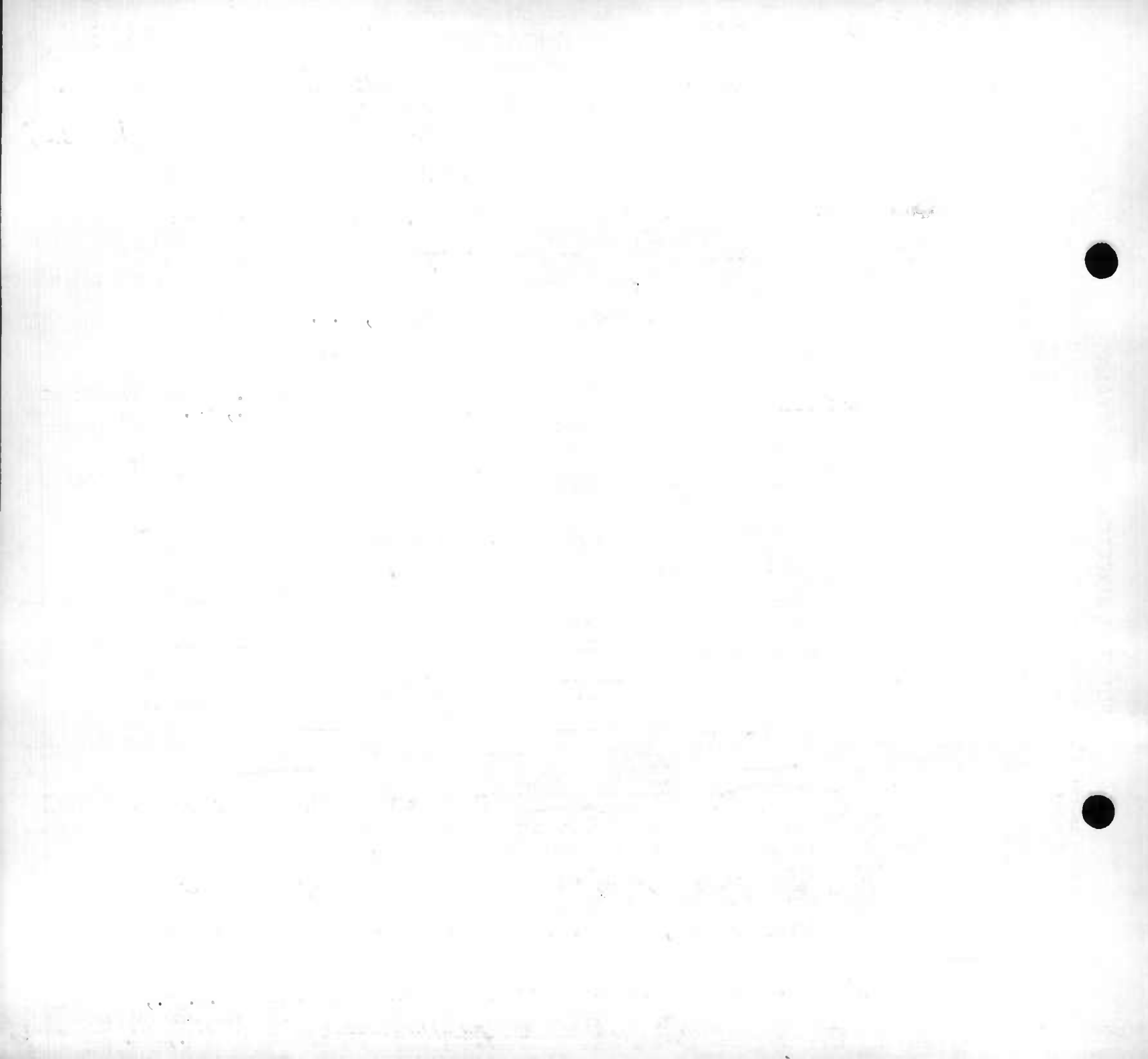




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9118</u>	
B-200 71 9118		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BASS, Blanche		9/28/71 6:10 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  33 The Johns Hopkins Hospital			A. STATE Maryland		
			B. COUNTY		
C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 224 S. Washington Street		
5. SEX Female	6. RACE N White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/4/17	9. AGE (In years last birthday) 54	10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Otha Snyder			
14. MOTHER'S MAIDEN NAME Mable Burnett		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.		17. INFORMANT Donna Close			
18. 590.1 4303.2		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Grim negative Sepsis with Shock			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Acute pyelonephritis			
		(C) Chronic Alcoholism			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days			
19A. DATE OF OPERATION 2 Nov		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Doubt		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 23, 1971 to Sept. 28, 1971 that (I) (we) last saw the deceased alive on Sept. 28, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walter Malloy, M.D.				23B. DATE SIGNED 9-28-71	
23C. PHYSICIAN'S NAME (Type) Walter Malloy, M.D.				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-1-71		24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Gardens	
24D. LOCATION Glen Burnie, A.A.Co., Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 1 1971			
25B. NAME OF REGISTRAR R. E. Taylor, M.D.		25C. FUNERAL DIRECTOR McCully Funeral Home			
25D. ADDRESS 237 Patapsco Avenue		25E. ADDRESS Balto., Md. 21225			

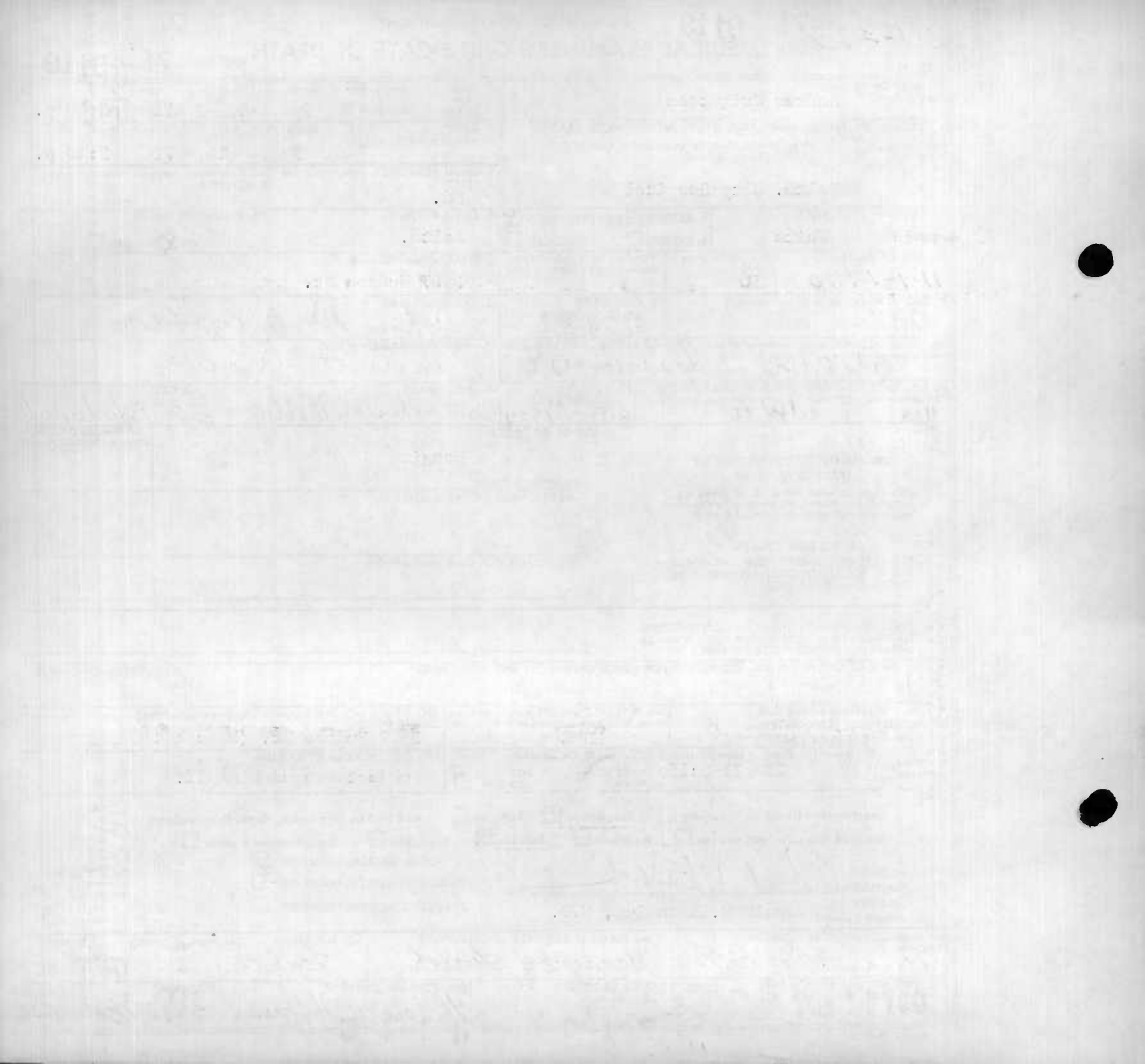


W-623<sup>71</sup> 9119 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. 71 9119

BIRTH NO. \_\_\_\_\_

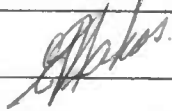
1. NAME OF DECEASED (Type or Print) <u>Andrew Wrightson</u>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <u>9</u> Day <u>28</u> Year <u>71</u> Hour <u>3:40</u> P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Balto. City Hospital</u>		3. DATE PRONOUNCED DEAD Month <u>9</u> Day <u>28</u> Year <u>71</u> Hour <u>3:40</u> P.M.	
6. SEX <u>male</u>		7. RACE <u>White</u>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Balto.</u>	
9. DATE OF BIRTH <u>11-1-1970</u>		10. AGE (In years lost birthday) <u>50</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John B. Wrightson</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Rowe</u>	
15. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2609</u>		E. STREET AND NUMBER <u>3907 Hudson St.</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WW II</u>		17. SOCIAL SECURITY NO. <u>218-01-1934</u>	
18. INFORMANT <u>Mrs. Catherine Mobley</u>		ADDRESS <u>3907 Hudson St.</u>	
19. <u>E 953 K</u>		CAUSE OF DEATH <u>Hanging</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____	
20A. DATE OF OPERATION <u>0</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
21. AUTOPSY? (Yes or No) <u>no</u>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>HOME</u>	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <u>3907 Hudson St. (basement)</u>		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <u>9 28 71 3:15 p.m.</u>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <u>Subject hanged himself.</u>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Ronald N. Kornblum</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Ronald N. Kornblum, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-1-71</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 1 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Zabor</u>	
25C. FUNERAL DIRECTOR <u>Helma A. Hoffmann</u>		ADDRESS <u>3218 Hudson St.</u>	

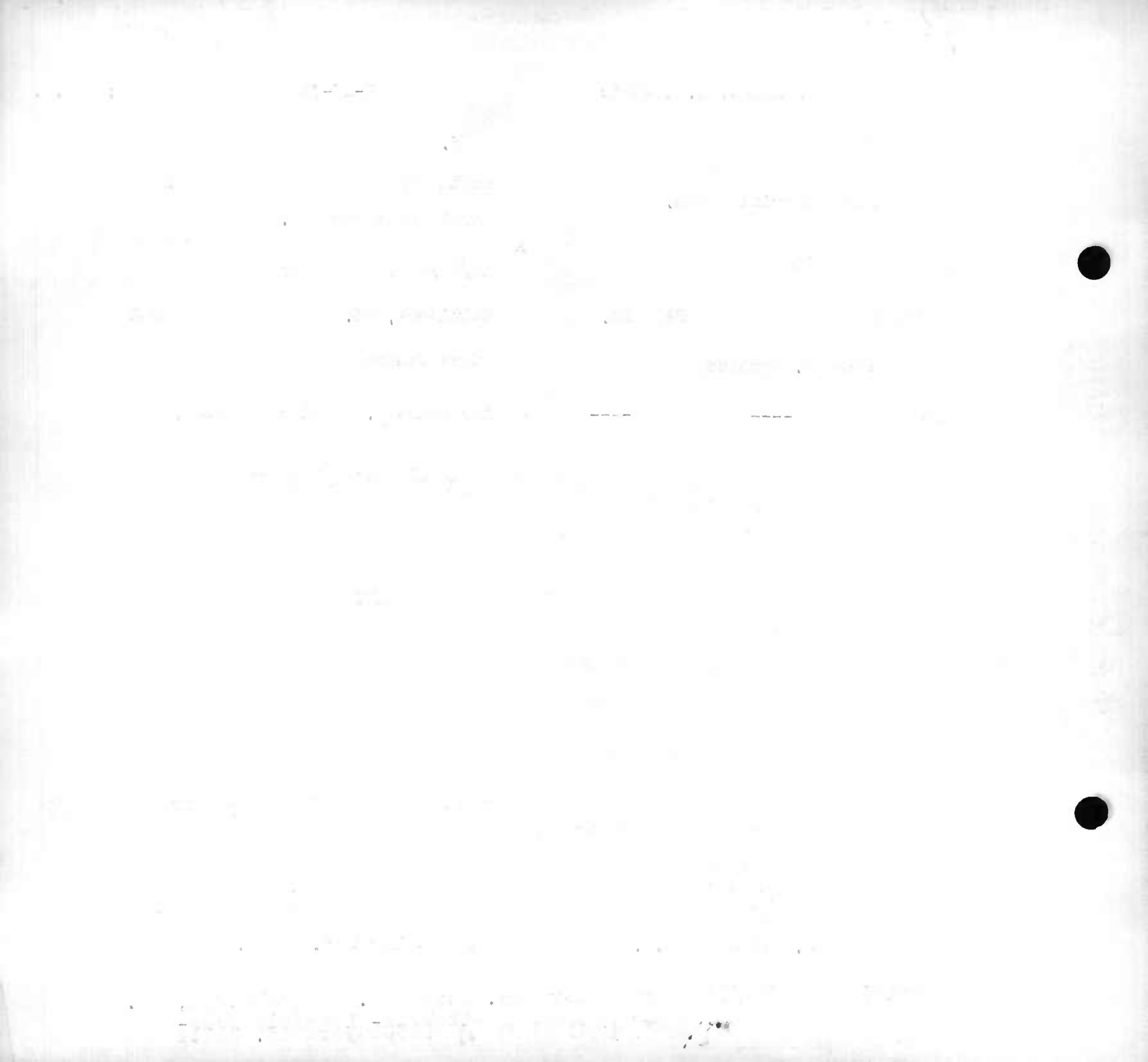
VS 151-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

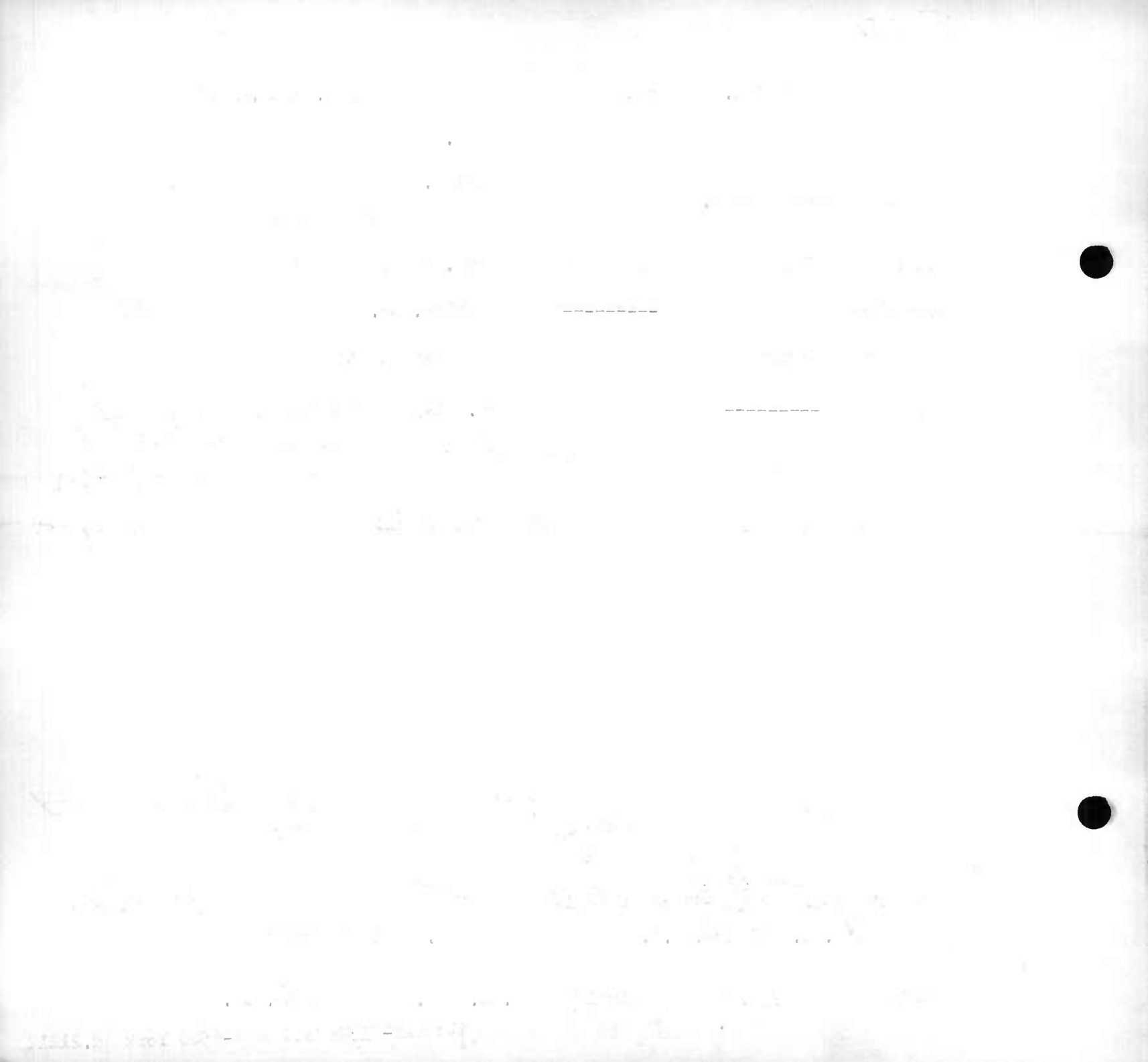
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9120</u>	
BIRTH NO. <u>71 9120</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>ROBBINS, M. Beatrice</b>			2. DATE AND HOUR OF DEATH <b>9-27-71 4:30 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 Union Memorial Hospt.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2758</b>		
5. SEX <b>Female</b>			6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>11/11/1897</b>			9. AGE (In years last birthday) <b>73</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(Ret)</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13. FATHER'S NAME <b>Richard L. Robbins</b>			14. MOTHER'S MAIDEN NAME <b>Cora Cannon</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>----</b>		17. INFORMANT <b>Miss Lenna F. Robbins (Sister)</b>
18. <b>427.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>II</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute CHF</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>9-22</b> 19 <b>71</b> to <b>9-22</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>9-22-71</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED <b>9/27/71</b>		23C. PHYSICIAN'S NAME (Type) <b>G. Nahas M.D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>9/30/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Park Cem.</b>
24D. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>			25A. DATE REC'D BY HEALTH DEPT. <b>OCT 1 1971</b>		
25B. NAME OF REGISTRAR <b>Robert E. Smith</b>			25C. FUNERAL DIRECTOR <b>Mitchell Wiedefeld</b>		
25D. ADDRESS <b>16500 York Rd. 21212</b>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 9121
CERTIFICATE OF DEATH				REG. NO. 71 9121
S-351 71 9121		BIRTH NO.		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Noami G. Stambaugh		Sept. 27th, 1971 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
44 Union Memorial Hospt.		Md. 1202		
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		417 Calvin Avenue		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 28th, 1886	85
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Homemaker		-----		Balto. Co.
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?		
Charles Johnson		USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
no -----				Mr. Clay Stambaugh (Son)
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Cerebrovascular accident		
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		ASCVD		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Oct 17 1969 to Sept 27 1971 and that (I) (we) last saw the deceased alive on May 7 1971 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
George T. Gilmore M.D.				9/29/71
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
Geo. T. Gilmore, M.D.		207 W. Seminary Avenue		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)	
Burial	9/30/71	Fairview Meth. Ch. Cem.	Balto. Co.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS		
OCT 1 1971	Robert E. Fisher, M.D.	Mitchell-Wisdefeld Home 6500 York Rd. 21212		

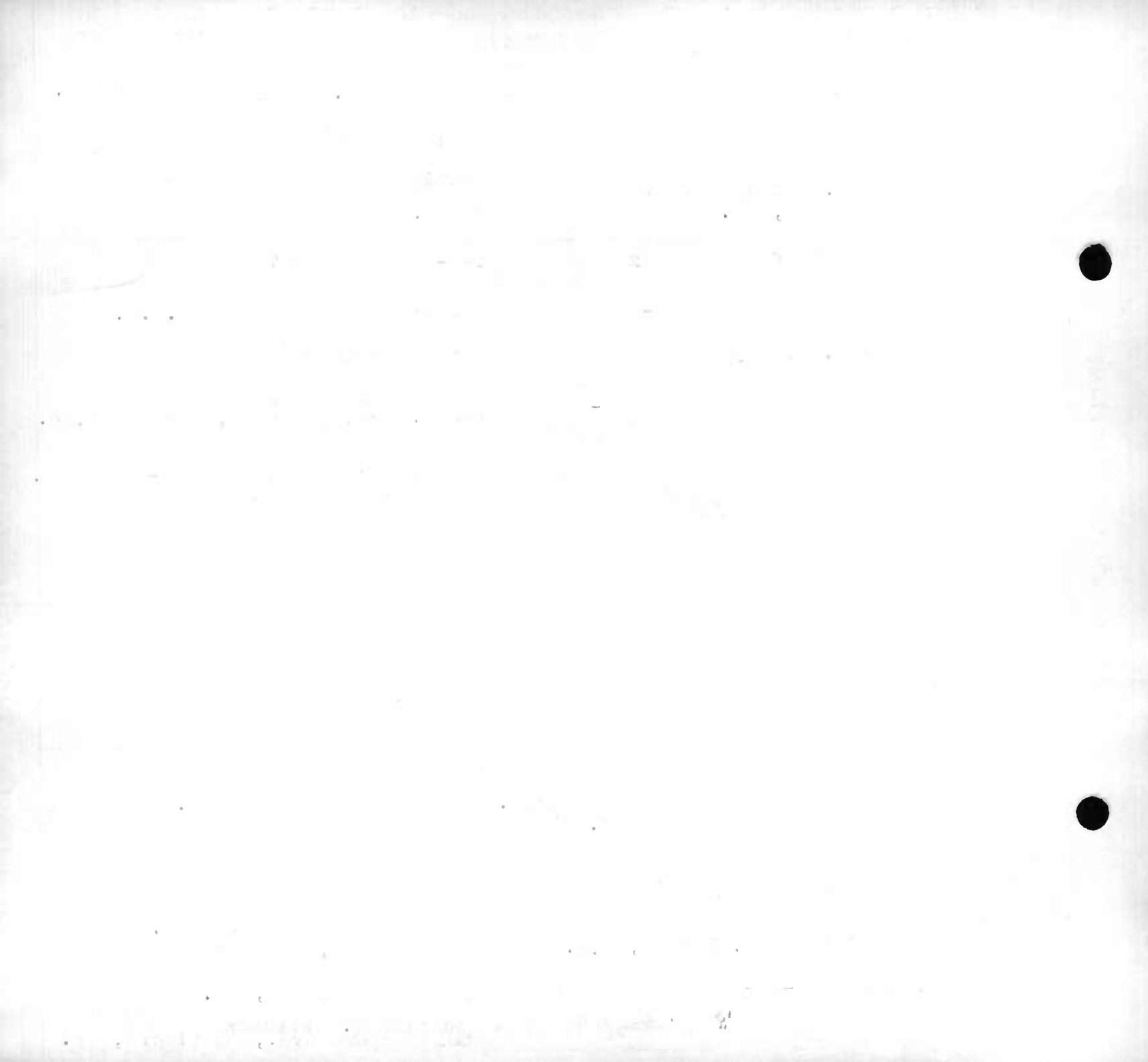




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 9122	
B-624 71 9122					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ELSIE BROCKLANDER		Sept. 27, 1971 6:03 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
00 522 S. Curley Street Baltimore, Md.		Maryland Baltimore 102			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Housewife		-		1-6-84	
11. BIRTHPLACE (State or foreign country)		9. AGE (In years last birthday)		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
Maryland		87			
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
U.S.A.		Gustave R. Schady			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
Mary Kretschmer		No			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
-		Edwin Brocklander 522 S. Curley Street, Baltimore, Md.			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE Arteriosclerotic Cardio-vascular Disease 4 yrs. DUE TO, OR AS A CONSEQUENCE OF					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 19 54 to Sept. 19 71 that (I) (we) last saw the deceased alive on Sept. 24 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Clarence W. LeDoux				23B. DATE SIGNED 29 Sept 1971	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Clarence W. LeDoux, M.D.				3023 Eastern Ave. Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		9-30-71		Parkwood Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 1 1971		Robert E. Vaden, Jr.		Nicholas T. Matthews 3021 Eastern Ave., Baltimore, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-620 71 9123</u>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>71 9123</u>	
1. NAME OF DECEASED (Type or Print) <u>MYERS, BERTHA L</u>				2. DATE AND HOUR OF DEATH <u>SEPTEMBER 28, 1971 11:15A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST. AGNES HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2582</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2044 DEERING AVE 21230</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03/07/03</u>	9. AGE (in years last birthday) <u>68</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN FLETCHER</u>				14. MOTHER'S MAIDEN NAME <u>LUCY HALL FLETCHER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>217-03-7692</u>		17. INFORMANT ADDRESS <u>ST. AGNES HOSPITAL RECORDS</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Dissecting Aneurysm - Thoracic Aorta</u> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: <u>Bronchogenic Carcinoma</u> <u>Pulmonary Emphysema</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR			
22. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 22 19 71</u> to <u>SEPTEMBER 28 19 71</u> that (I) (we) last saw the deceased alive on <u>SEPTEMBER 28 19 71</u> and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Donato A. Vargas Jr. M.D.</u>						23B. DATE SIGNED <u>9-28-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>DONATO A. VARGAS, JR., MD.</u>		23D. ADDRESS <u>BALTO. MD. 21229 ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-1-71</u>		24C. NAME OF CEMETERY OR CREMATOR <u>Glen Staven</u>		24D. LOCATION (City, town, or county) (State) <u>Glen Burnie. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 1 '71</u>		25B. NAME OF REGISTRAR <u>Robert E. J. ...</u>		25C. FUNERAL DIRECTOR <u>Frank D. Lutz</u>		ADDRESS <u>814 W 36 St. 21211</u>	

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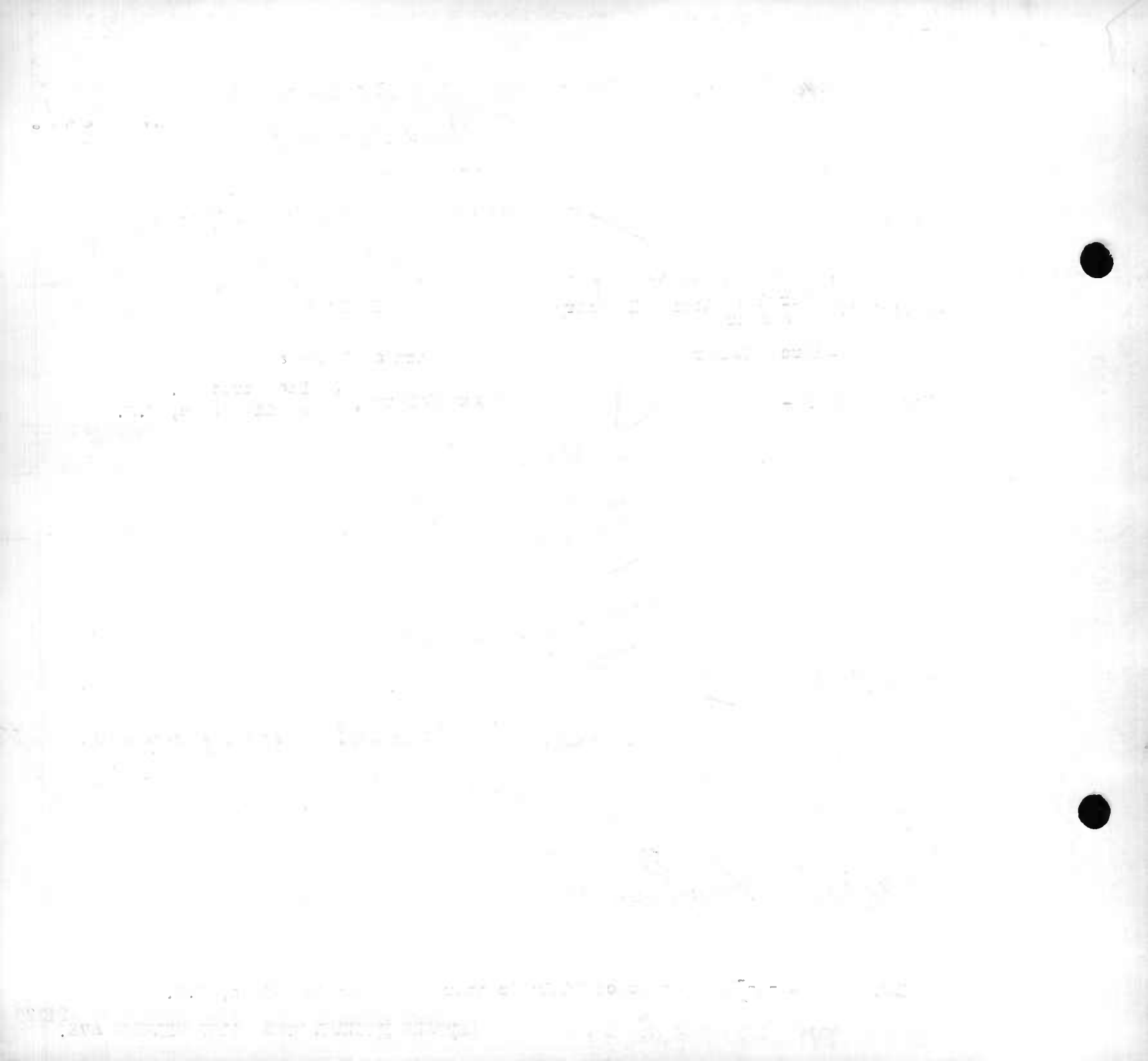
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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-162 71 9124		BIRTH NO.		Baltimore City Health Department		CERTIFICATE OF DEATH		REG. NO. 71 9124	
1. NAME OF DECEASED (Type or Print) <b>KENNETH LAPARCH</b>				2. DATE AND HOUR OF DEATH <b>28 SEPT 71 9:14 P.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>NEW JERSEY</b> B. COUNTY <b>V27</b>					
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSP</b>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>BASKING RIDGE</b>	
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER <b>60 PEACH TREE ROAD</b>					
5. SEX <b>M</b>	6. RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-13-27</b>	9. AGE (In years last birthday) <b>43</b>	If Under 1 Yr. Months: Days: Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service manager</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service manager</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Letton Industry</b>			11. BIRTHPLACE (State or foreign country) <b>MICHIGAN</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Alfred Laparch</b>			14. MOTHER'S MAIDEN NAME <b>Bertha Houseman</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1945 -</b>			16. SOCIAL SECURITY NO.			17. INFORMANT <b>Clara Laparch, 60 Peachtree Rd. Basking Ridge, N.J.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, ashenia, etc. It means the disease or injury or complication which caused death.) <b>BRONCHO PNEUMONIA</b>			CAUSE OF DEATH <b>BRONCHO PNEUMONIA</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 Days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CONCREAL CONFUSION</b>			DUE TO, OR AS A CONSEQUENCE OF: <b>CONCREAL CONFUSION</b>			8 Days			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Ruptured Spleen</b>			8 Days						
19A. DATE OF OPERATION <b>20 Sept 71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>US Rt 301 - 800 ft S of Rly 290 6700</b>					
21D. TIME OF INJURY (APPROX.) <b>Sept 20, 1971 1400</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Auto Accident - Passenger</b>					
22. I certify that (a) (this hospital) attended the deceased from <b>28 Sept 71</b> to <b>28 Sept 71</b> and that (b) (we) last saw the deceased alive on <b>28 Sept 71</b> and that (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Dr. Ker</b>				23B. DATE SIGNED <b>28 Sept 71</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Ker</b>			
23D. ADDRESS <b>HUBBARD FUNERAL HOME 4107 WILKENS AVE.</b>				23E. ADDRESS <b>21229</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-1-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Somerset Hills Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Basking Ridge, N.J.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 1 1971</b>		25B. NAME OF REGISTRAR <b>Dr. Ker</b>		25C. FUNERAL DIRECTOR <b>HUBBARD FUNERAL HOME</b>		25D. ADDRESS <b>4107 WILKENS AVE.</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

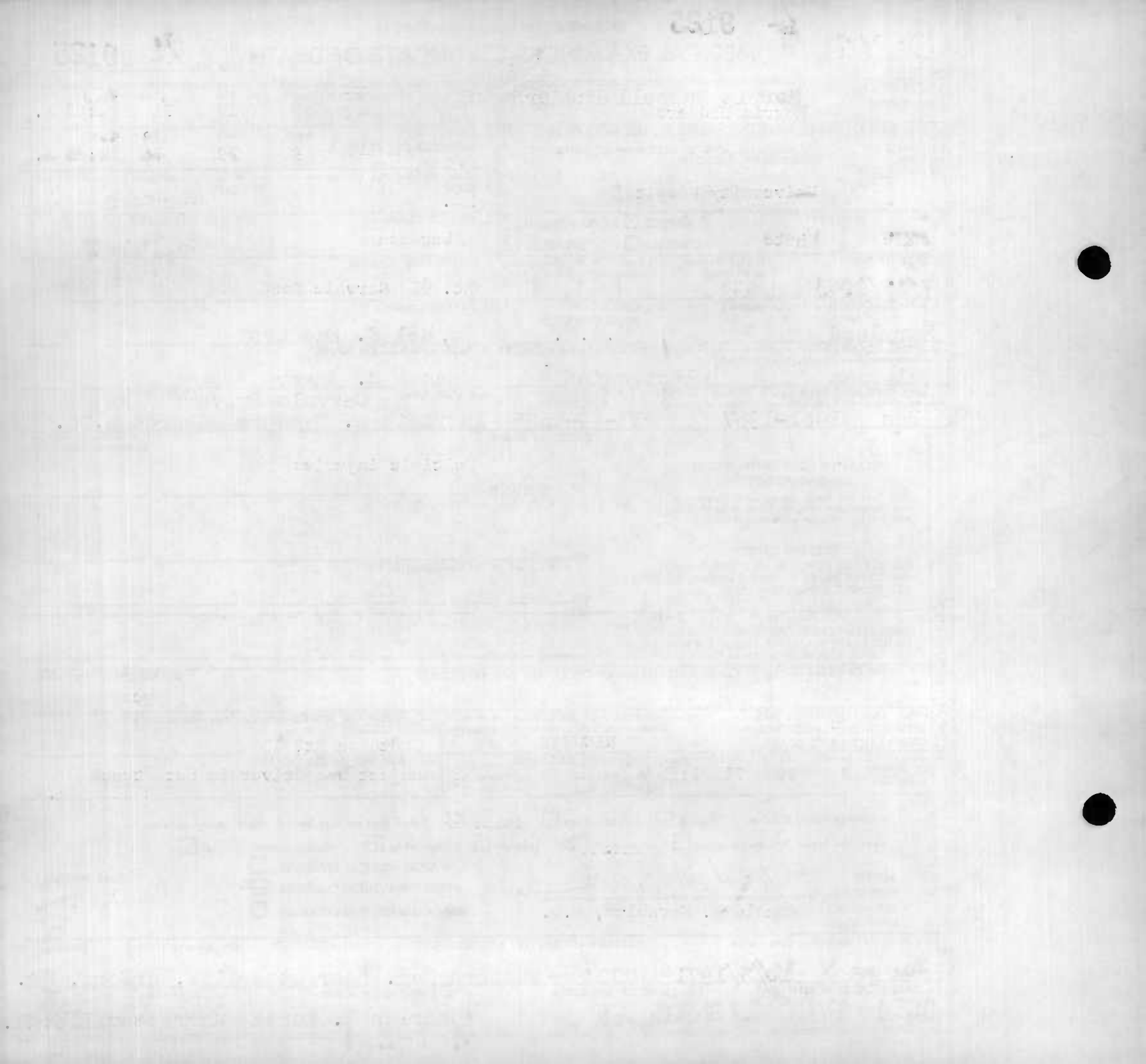
REG. NO.

71

9125

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Morris Russell Badders</b> <b>Morris Badders</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 29 Year 71 Hour 2:05 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month 9 Day 29 Year 71 Hour 2:05 a. M.	
6. SEX male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Aberdeen	
9. DATE OF BIRTH 7/15/1943		10. AGE (In years (last birthday) 28 # Under 1 Yr. # Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		14B. KIND OF BUSINESS OR INDUSTRY Electronics	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1961-1967		17. SOCIAL SECURITY NO. 213-44-9525	
18. INFORMANT Patricia A. Badders		18. ADDRESS RD #1 Aberdeen, Md.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HIGHWAY	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) South on Rt. 136		22F. HOW DID INJURY OCCUR? Subject was driver in auto/truck collision.	
22D. TIME OF INJURY (APPROX.) 9 29 71 1:05 a. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/29/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/3/1971	
24C. NAME OF CEMETERY or CREMATORY William Watters Mem.		24D. LOCATION (City, town, or county) (State) Jarrettsville, Harford, Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 1 1971		25B. NAME OF REGISTRAR Charles E. Kurtz	
25C. FUNERAL DIRECTOR Charles E. Kurtz		25D. ADDRESS Jarrettsville, Md. 21084	





W-425 71

9126

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9126

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Inene Wilson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 29 Year 71 Hour 4:30 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital		3. DATE PRONOUNCED DEAD Month 9 Day 29 Year 71 Hour 4:30 a. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1602			
6. SEX female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 11/14/1938		10. AGE (in years last birthday) 32	E. STREET AND NUMBER 1021 N. Calhoun St.
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 219-26-2705	18. INFORMANT ADDRESS
19. CAUSE OF DEATH 571.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cirrhosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/29/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 10/8/71	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town or county) (State) A.A. County, Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 1 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR John P. Smith		ADDRESS 1712 W. North Ave.	

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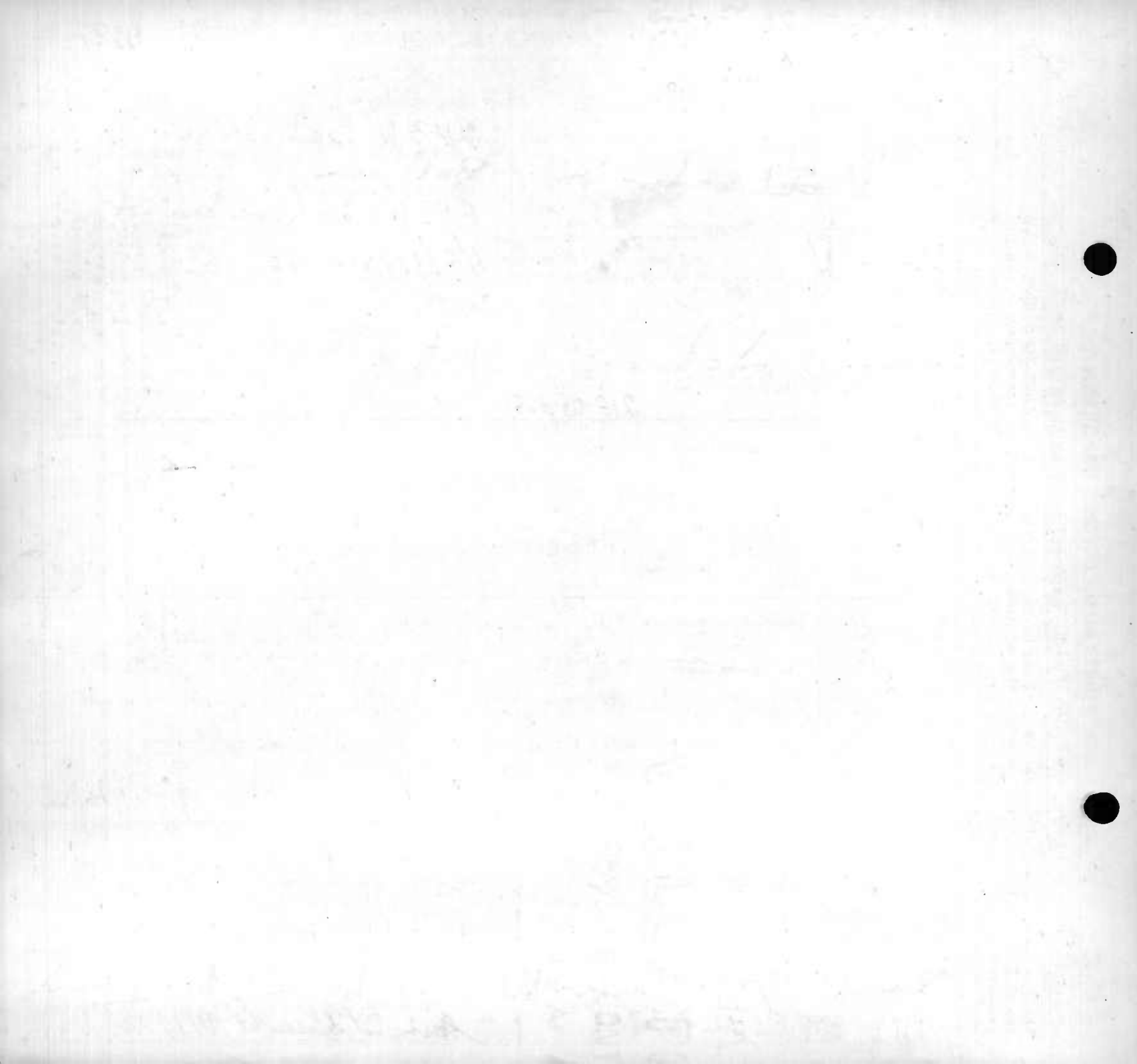
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 9127	
J-525 71 9127		BIRTH NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
William Johnson		9/29/71 3:10 P M.			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN		6. INSIDE CITY LIMITS?	
223 N. Schroeder A, 1801		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		8. STREET AND NUMBER		9. AGE (In years last birthday)	
223 N. Schroeder A.		223 N. Schroeder A		70	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTH PLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		Rd Smith		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Jessie Johnson		Hattie			
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
218-05-3685					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
162.1 I		Carcinoma of Lung		Months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
None				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/5/71 to 9/29/71, that (I) last saw the deceased alive on 9/11/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Typed)	
J. MacPhillips		9/30/71		J. MacPhillips MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		10/3/71		Carter Memorial Home, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 1 1971		Robert E. Fisher, Jr.		John J. Lamm 1712 W. North	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9128</u>	
BIRTH NO. <u>P-620 71 9128</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>PIERCY EVA</u>		2. DATE AND HOUR OF DEATH <u>9/29/71</u> <u>4:20 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>THE UNION MEMORIAL HOSPITAL</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2854</u>			
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>GREENWICH AVE. 5112, Apt. D1</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-27-03</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>Late Raymond Wigington</u> <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>late Bessie</u> <u>UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-09-8114A</u>		17. INFORMANT <u>Apt D-1</u> <u>Mr. Robert T. Piercy, 5112 Greenwich Ave.</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIOGENIC SHOCK</u> (B) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ARTERIOCLEROTIC CARDIOVASCULAR DISEASE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/25/71</u> 19 <u>71</u> to <u>9/29/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/29/71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joe A. Pa</u>		DEGREE <u>JOSE PAZ</u>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>JOSE PAZ</u>		23D. ADDRESS <u>Union Memorial Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/2/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Crestlawn Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Marriottsville, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 1 1971</u>		25B. NAME OF REGISTRAR <u>Reese</u>		25C. FUNERAL DIRECTOR <u>Witzke</u> ADDRESS <u>1630 Edmondson Ave., 21228</u>	

THE UNIVERSITY OF CHICAGO

1950

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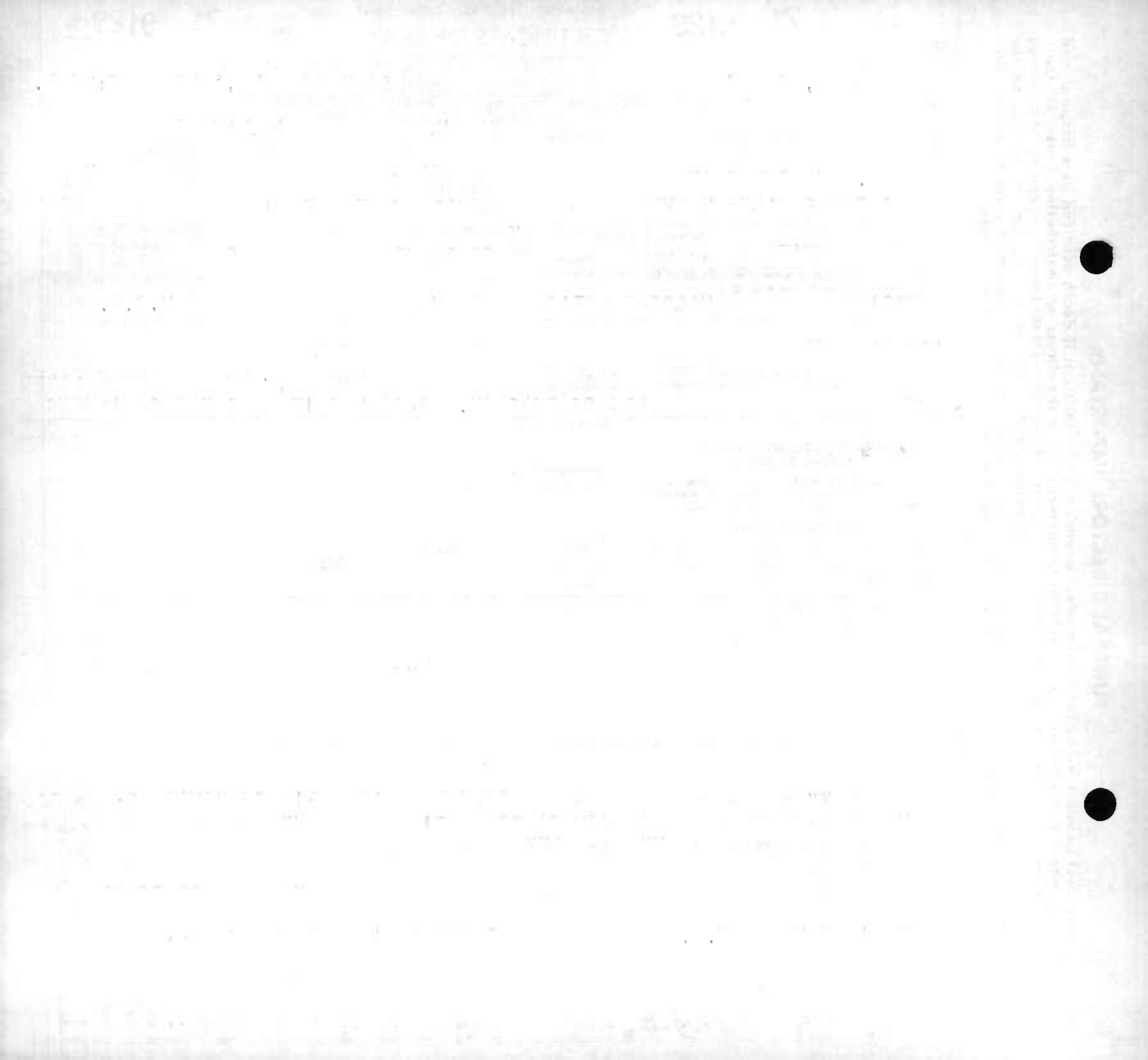
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1950-51

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9129</span>	
<h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>					
BIRTH NO. <span style="font-size: 1.5em;">L-320</span>					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">LOTZ, GEORGE</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">SEPTEMBER 29, 1971</span> <span style="float: right;">5:20 P. M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">40</span> ST. AGNES HOSPITAL CATON & WILKENS AVE		A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE</span> <span style="float: right;">5300</span>			
		C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <span style="font-size: 1.2em;">6012 BURNT OAK RD</span>		<span style="font-size: 1.2em;">21228</span>	
5. SEX <span style="font-size: 1.2em;">MALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">02 10 01</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">70</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">OPTICIAN</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">HILBERT OPTICAL</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>					
13. FATHER'S NAME <span style="font-size: 1.2em;">MICHAEL LOTZ</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">BARBARA ROSEL</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">215 05 3543</span>		17. INFORMANT <span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span> ADDRESS <span style="font-size: 1.2em;">21229</span> <span style="font-size: 1.2em;">ST. AGNES HOSPITAL CATON &amp; WILKENS AVE</span>	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><span style="font-size: 1.5em;">410.91</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Acute Myocardial infarction</span></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Thrombosis of ① Left Ant. descending and Right Coronary arteries</span></p> <p>(C) <span style="font-size: 1.2em;">Atherosclerosis of Arteries</span></p> </div> </div>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> </div> <div style="width: 50%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">YES</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(X)</del> (this hospital) attended the deceased from <span style="font-size: 1.2em;">SEPTEMBER 27, 1971</span> to <span style="font-size: 1.2em;">SEPTEMBER 29, 1971</span> that <del>(X)</del> (we) last saw the deceased alive on <span style="font-size: 1.2em;">SEPTEMBER 29, 1971</span> and that in <del>(X)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(X)</del> (We) (did) (d) <del>(X)</del> view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Tariq Mahmood</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">09 30 71</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">TARIQ MAHMOOD M.D.</span>				23D. ADDRESS <span style="font-size: 1.2em;">CATON &amp; WILKENS AVENUE 21229</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">10/2/71</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Sacred Heart of Jesus Catholic Cemetery of the</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">OCT 1 1971</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Talley, R.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Witzke, 1630 Edmondson Ave., 21228</span>	





# FUNERAL DIRECTOR: IMPORTANT

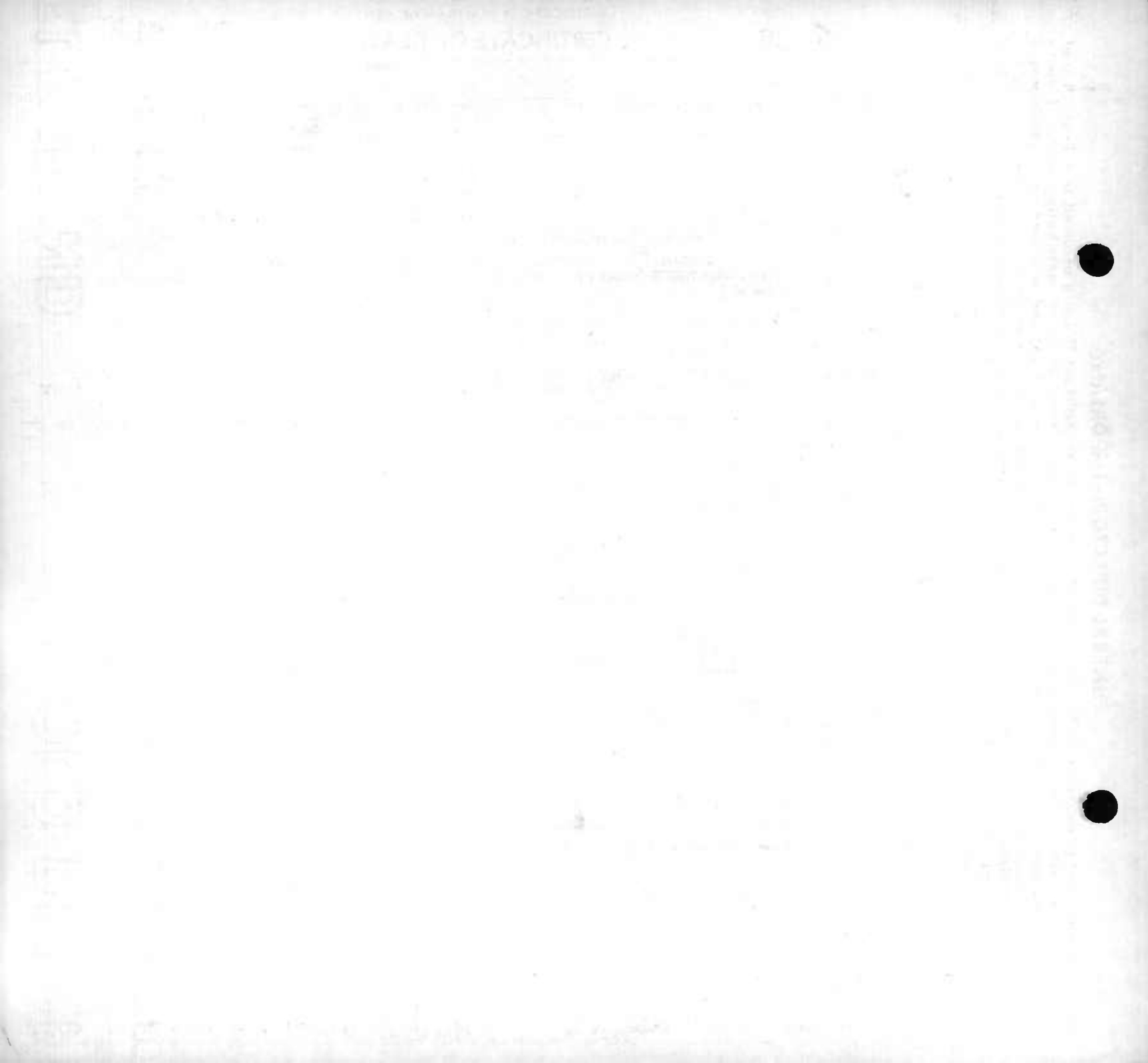
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **71 9130**

BIRTH NO. **71 9130**

1. NAME OF DECEASED (Type or Print) <b>LOUISE TYLER</b>		2. DATE AND HOUR OF DEATH <b>9/29/71 17:47 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2716</b>	
5. SEX <b>F</b>		6. RACE <b>N</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/4/07</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <b>64</b>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Norfolk, Virginia</b>	
13. FATHER'S NAME <b>Samuel Barnhill</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
14. MOTHER'S MAIDEN NAME <b>Martha Coenick</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Roberta Harding</b> ADDRESS <b>3409 - Park Heights Ave</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>410.9 I</b> <b>CAUSE OF DEATH</b> <b>Cardiac Arrest</b> <b>Probable massive M.I.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/29</b> 19 <b>71</b> to <b>9/29</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>9/29</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Robert E. Brenner, M.D.</b>		23B. DATE SIGNED <b>9/29/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert E. Brenner, M.D.</b>		23D. ADDRESS <b>Sinai Hospital Balto Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-2-71</b>	
24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE RECD BY HEALTH DEPT. <b>10/1</b>		25B. NAME OF REGISTRAR <b>Robert E. Brenner, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Horatio A. Byett</b>		25D. ADDRESS <b>Ft. 1701 - Laurens St.</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9131

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES WATTS

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

September 30, 1971

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location of home or institution)

Church Home &amp; Hospital (DOA)

3. DATE

PRONOUNCED DEAD

Month

Day

Year

Hour

September 30, 1971

7:45 A.

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Nov, 8, 1897

10. AGE (In years last birthday)

73

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

222 Douglas Court

11. BIRTHPLACE (State, or foreign country)

St. Mary's Count, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Unknown

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

Retired

15. MOTHER'S MAIDEN NAME

Mary Watts

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Arlene Ingram 220 N. Dallas Ct.

19. E982X1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

~~Arteriosclerotic cardiovascular disease~~

(A) IMMEDIATE CAUSE

Carbon monoxide intoxication

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

222 Douglas Court

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

9-30-71

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 30, 1971

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10-4-71

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

OCT 1 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Morton &amp; Dyett F. H. 1701 Laurens St.

ADDRESS

Letter from M.E.'s office

10-4-71 M.H.

ACADEMY BOND

RAE CONTENT

VIDEO CASSETTES

U.S.A.

1/2

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 9132</b>
BIRTH NO. <b>71 9132</b>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Williams, Matthew</b>		2. DATE AND HOUR OF DEATH <b>9/29/71 9:45 p.m.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1510</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hosp.</b>		C. CITY OR TOWN <b>Baltimore</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>3818 Belle Avenue</b>				
5. SEX <b>M</b>	6. RACE <b>Black</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/18/32</b>	9. AGE (in years last birthday) <b>38</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Virginia Donut</b>		11. BIRTHPLACE (State or foreign country) <b>Manning, S. C.</b>
13. FATHER'S NAME <b>Samuel Williams</b>		14. MOTHER'S MAIDEN NAME <b>Rosa Felder</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>249-44-5020</b>		17. INFORMANT <b>Mrs. Maggie Cosby 820 N. Augusta Ave.</b>
18. <b>431.0</b>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Thalamic hemorrhage</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>1 1/2 yrs.</b>
(C) _____				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>0</b>				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>9/28</b> 19 <b>71</b> to <b>29</b> 19 <b>71</b> that (we) last saw the deceased alive on <b>9/29</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Joseph P. Finizio MD</b>		23B. DATE SIGNED <b>9/29/71</b>		
23C. PHYSICIAN'S NAME (Type) <b>Joseph P. Finizio MD</b>		23D. ADDRESS <b>The Johns Hopkins Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-4-71</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 1 1971</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor MD</b>	25C. FUNERAL DIRECTOR <b>Monton &amp; Dyett</b>	ADDRESS <b>F. H. 1701 Laurens St.</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED  
(Type or Print)

Robert Johnson

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐Month  
Day  
Year9  
28  
71Hour  
Minute

5:50 p. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1330 N. Stockton Street

3. DATE  
PRONOUNCED DEADMonth  
Day  
Year9  
28  
71Hour  
Minute

5:50 p. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE  
Md.

B. COUNTY

1606

6. SEX

male

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Nov 27-1934

10. AGE (In years  
last birthday)

36

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2838 W. Lanvale

11. BIRTHPLACE (State or foreign country)

BALTO MD

12. CITIZEN OF

USA

13. FATHER'S NAME

Robert Johnson

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

SHIP YARD

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Alma L. Tizog

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Dorothy Johnson 2838 W. Lanvale

19.

412.214250.9

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Hypertensive cardiovascular disease

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

Diabetic mellitus

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED.

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/29/71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/27/71

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION

(City, town, or county)

(State)

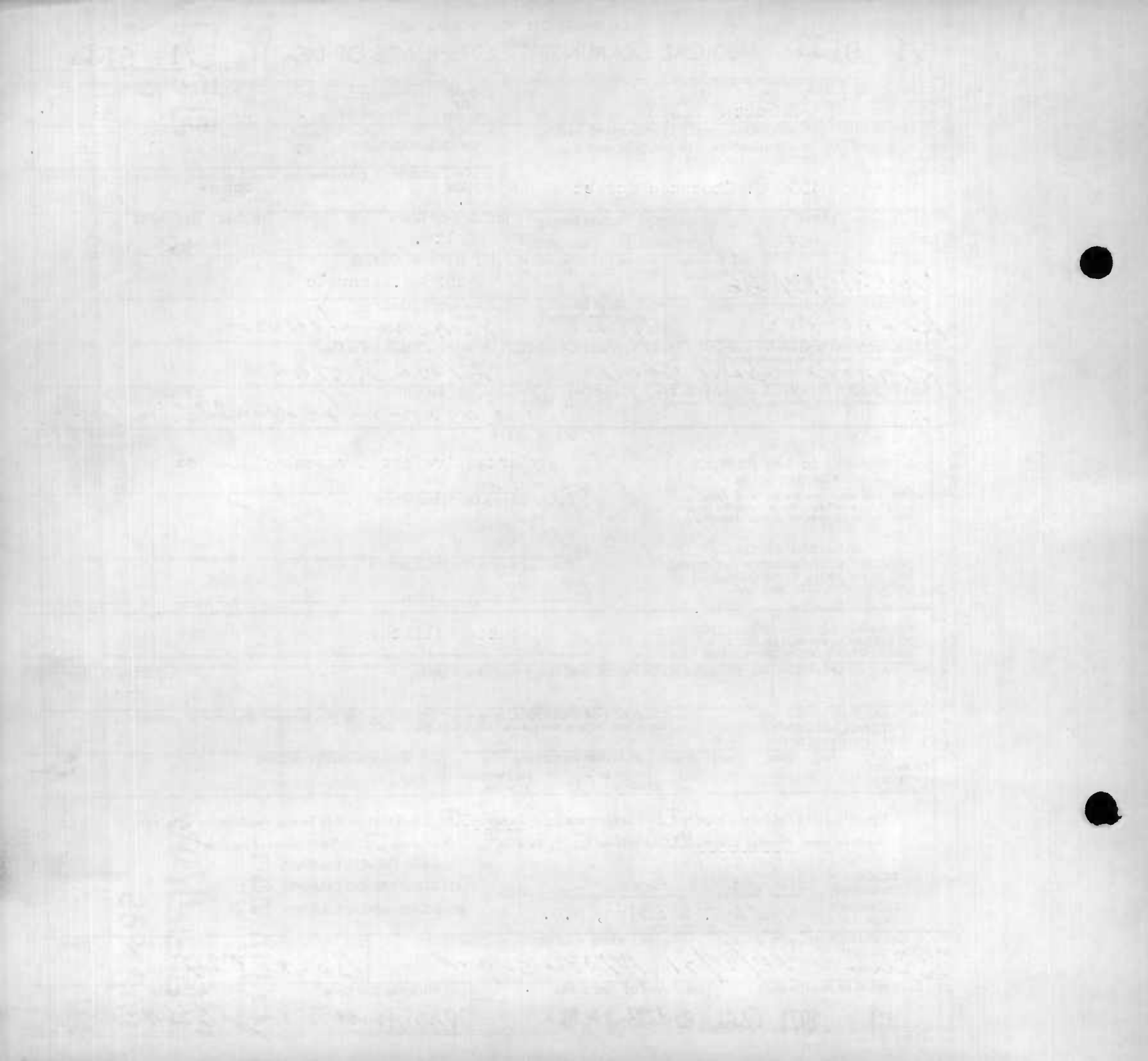
BALTO MD

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 71 9134

BIRTH NO. 71 9134		1. NAME OF DECEASED (Type or Print) REED, HELEN		2. DATE AND HOUR OF DEATH 9-29-71 8:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MD IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3026 Belmont Ave.		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-07-17	9. AGE (in years last birthday) 53 7/8	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto Md.	
13. FATHER'S NAME William Emerson Sr.			14. MOTHER'S MAIDEN NAME Vester Page		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO.		17. INFORMANT William Emerson 2804 Windsor Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 174X I CA breast with metastasis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 9-26-1971 to 9-29-1971 that (Y) (we) last saw the deceased alive on 9-29-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE AJAZ ARAIN MD			23B. DATE SIGNED 9-29-71		23C. PHYSICIAN'S NAME (Type) AJAZ ARAIN MD
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 10/2/71		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.
25A. DATE REC'D BY HEALTH DEPT. OCT 1 1971			25B. NAME OF REGISTRAR Robert E. Farley, R.D.		25C. FUNERAL DIRECTOR William Emerson Home 319 N. Belvoir St.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 9135	
BIRTH NO. 71 9135		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>MARY DELIA Shipley</u>			2. DATE AND HOUR OF DEATH <u>9-29-71</u> <u>9 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>43 South Balto General Hosp</u> <u>3001 So. Hanover St.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-38</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3515 Springdale Ave.</u>		
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-95</u>	9. AGE in years last birthday <u>76</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>Nellie Smith</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>212-22-2481-J1</u>		17. INFORMANT <u>Marion Wade</u> ADDRESS <u>same</u>
18. <u>570.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>A.S.C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Pyelonephritis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>9-29-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-10-1971</u> to <u>9-29-1971</u> that (I) (we) lost saw the deceased alive on <u>9-29-1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Hargit Singh M.D.</u>			23B. DATE SIGNED <u>9/29/71</u>		23C. PHYSICIAN'S NAME (Type) <u>HARGIT SINGH M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>10-4-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Pk.</u>
24D. LOCATION (City, town, or county) <u>Balto., Md.</u>			25A. DATE REC'D BY HEALTH DEPT. <u>OCT 1 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Tuba, M.D.</u>			25C. FUNERAL DIRECTOR <u>V. Bailey</u> ADDRESS <u>1348 Calhoun St.</u>		



more used - Dr. Kohnenberger  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

VIRGINIA BANKS

2. DATE AND HOUR OF DEATH

9/28/71 2:45 PM

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE  
MARYLAND

B. COUNTY

C. CITY OR TOWN  
BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2411 LAKEVIEW AVE.

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

06 01 07

9. AGE (In years  
last birthday) 6411. Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Geo. HENRY CLAYTON

14. MOTHER'S MAIDEN NAME

JUDY GREEN

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Bessie Barbee 1704 N. Fulton Ave.

18.

410.8 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

MYOCARDIAL INFARCTION

(B)

DUE TO, OR AS A CONSEQUENCE OF:

ASCITIS

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/28 to 9/28 1971  
that (I) (we) last saw the deceased alive on 9/28 1971 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S  
NAME (Type)

J. HAROLD HELDEMAN, M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

9/28/71

23D. ADDRESS

THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

10-2-71

24C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Park

24D. LOCATION

(City, town, or county)

Balto., Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

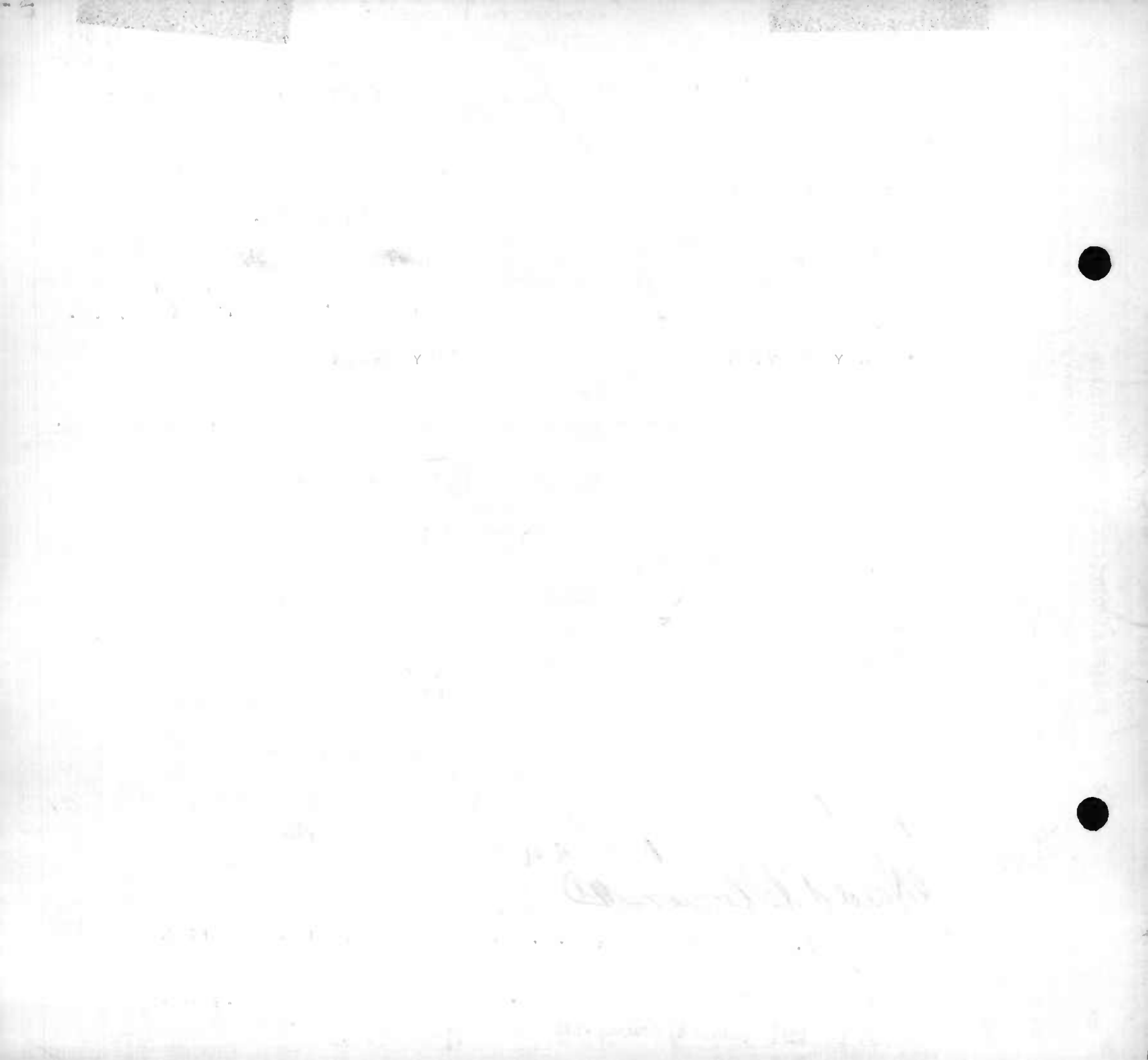
25C. FUNERAL DIRECTOR

ADDRESS

JUL 1 1971

Robert E. Farley, R.D.

Kelson E. H. 2 1348 Calhoun Street



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-400 71 9137		BALTIMORE CITY HEALTH DEPARTMENT		71 9137	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Charles C. ELLY JR		Sept 28, 1971 9:25 P			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
00 2113 Westfield Ave		Maryland		2706	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M		N		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
SALES		Sears Roebuck		MARCH 19, 1944 57	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
Charles C. ELLY Sr		Bertha GLRITZ		11 Under 1 Yr. Months Days Hours Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				Anne ELLY	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1. 162.1 I		Carcinoma of Lung		6 months	
1. This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
2. ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 48 to Sept 27, 19 71 and that (I) (we) last saw the deceased alive on Sept 27, 19 71 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
George H. Beck MD		9/30/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
George H. Beck		6012 Harford Rd Baltimore, Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		10-1-1971		Moreland Memorial	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 1 1971		Robert E. Jaber, MD		Chas. F. Evans & Son 8802 Harford Rd	

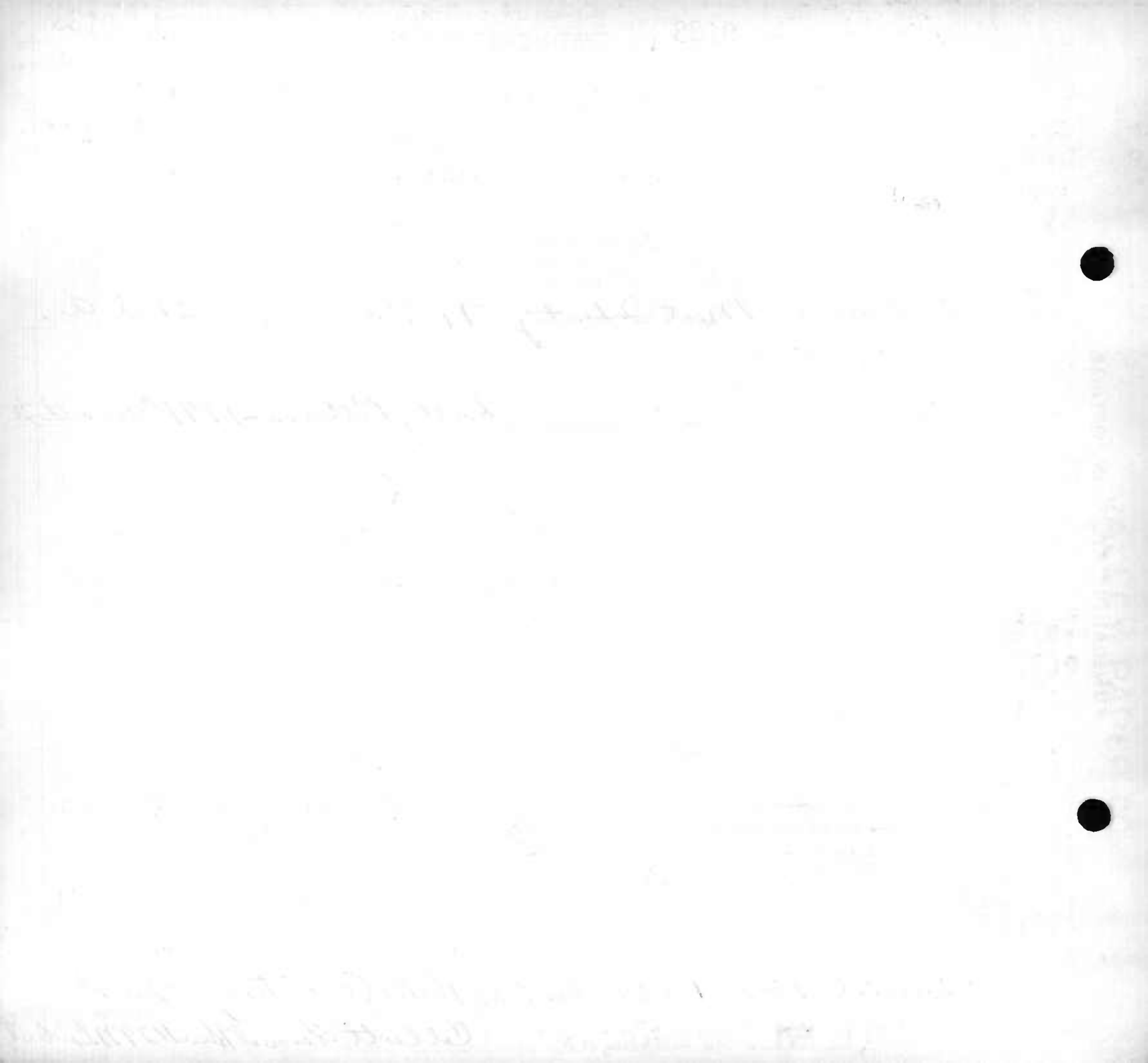




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-355 71 9138				BALTIMORE CITY HEALTH DEPARTMENT		71 9138	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>HAROLD PITTMAN</b>				2. DATE AND HOUR OF DEATH <b>1:15 PM 28 Sept 71</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 JOHN S HOPKINS HOSP.</b>				A. STATE <b>Maryland</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY <b>804</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2223 E. Preston Street</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/13/23</b>		9. AGE (in years last birthday) <b>48</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labour - Meat Industry</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carey Pittman</b>				14. MOTHER'S MAIDEN NAME <b>Manie Horton</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Betty Pittman - 1741 Ellsworth St.</b>	
18. <b>431.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Hypoxia</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>CEREBRAL HEMORRHAGE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 MIN</b> <b>24 hrs</b> <b>4 DAYS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>HYPERTENSION</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>24 Sept 1971</b> to <b>28 Sept 1971</b> that (I) (we) last saw the deceased alive on <b>28 Sept 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Keith L. Klein MD</b>						23B. DATE SIGNED <b>28 Sept 71</b>	
23C. PHYSICIAN'S NAME (Type) <b>KEITH L. KLEIN</b>						23D. ADDRESS <b>The Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>10-2-71</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Arbutus Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 1 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Kelly, Jr.</b>		25C. FUNERAL DIRECTOR <b>William H. Howell</b>		ADDRESS <b>1297 Carroll St.</b>	



B-652

S-53071

9139

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9139

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Vivian Smith (Hardin Barnes)

2. DATE  
OF DEATHKnown ☒ Estimated ☐

Month Day Year

9 24 71

Hour

3:00 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1601 Harford Avenue

3. DATE  
PRONOUNCED DEAD

Month Day Year

9 24 71

Hour

3:00 p.m.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Md.

B. COUNTY

909

6. SEX

female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Aug 21, 1919

10. AGE (In years  
lost birthday)

52

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1601 Harford Avenue

11. BIRTHPLACE (State or foreign country)

N. Carolina

12. CITIZEN OF  
WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

Thomas M. Keven

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Marion Barnes

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Lola Evans 1501 York Rd

19. E968X1

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Craneo-cerebral injuries

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

HOME

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1601 Harford Avenue

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY allegedly  
(APPROX.) Sept. 21, 71 unk.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject allegedly struck with blunt  
object.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/25/71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

24B. DATE

9-30-71

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

Middletown, Ohio

25A. DATE REC'D BY HEALTH DEPT.

OCT 1 1971

25B. NAME OF REGISTRAR

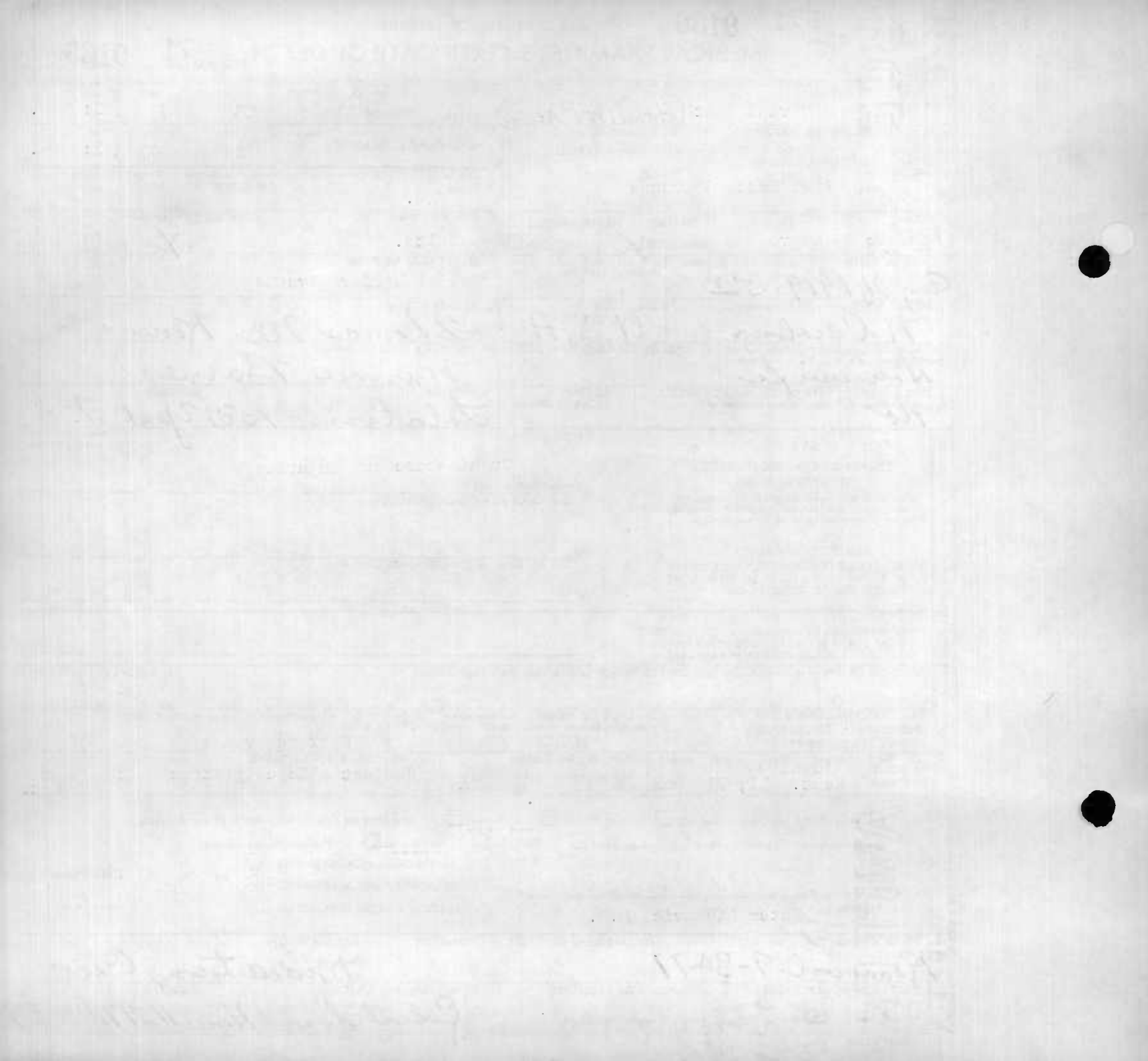
Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Elbert L. Lunsford

ADDRESS

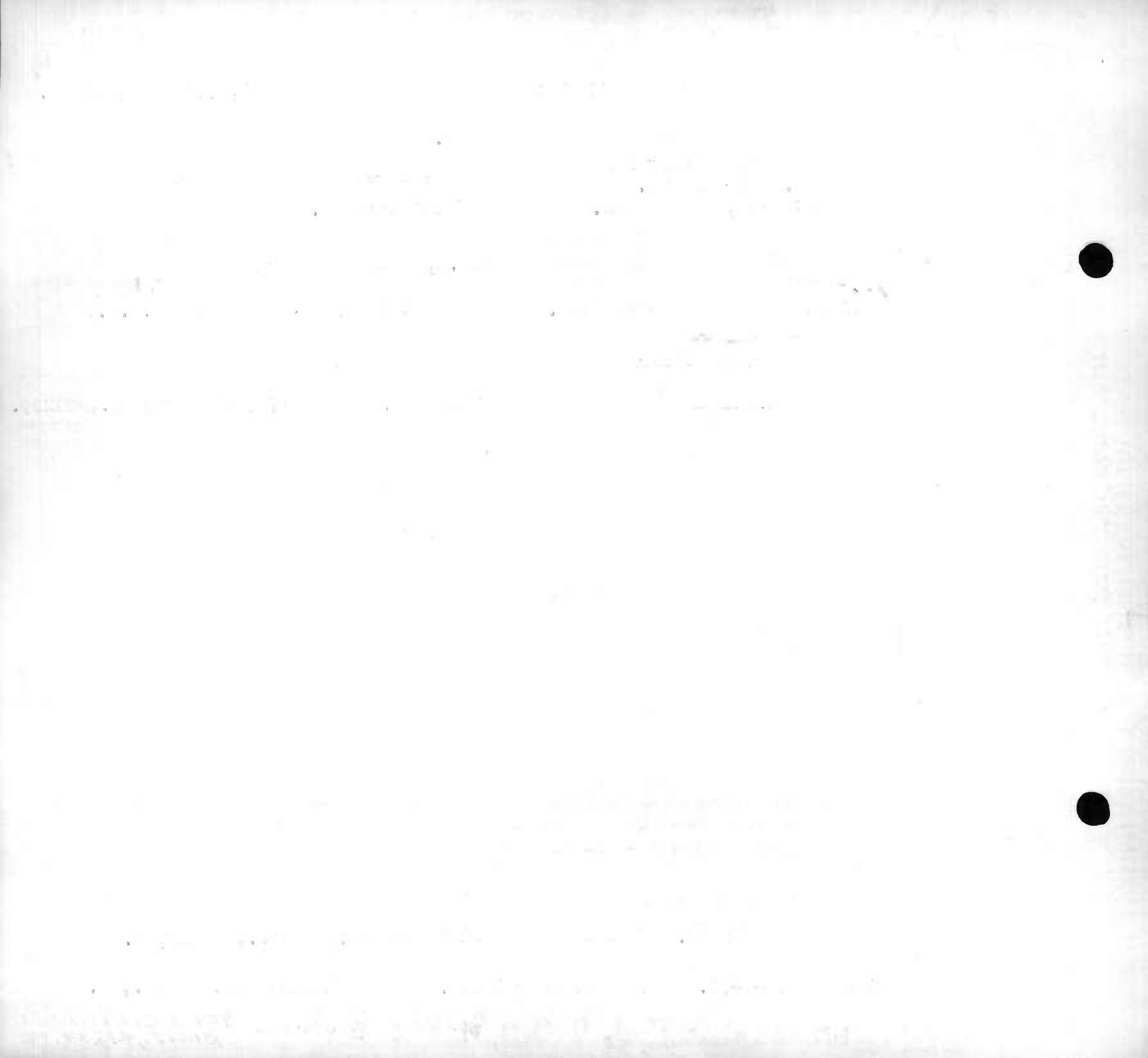
1129 N. Court St.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

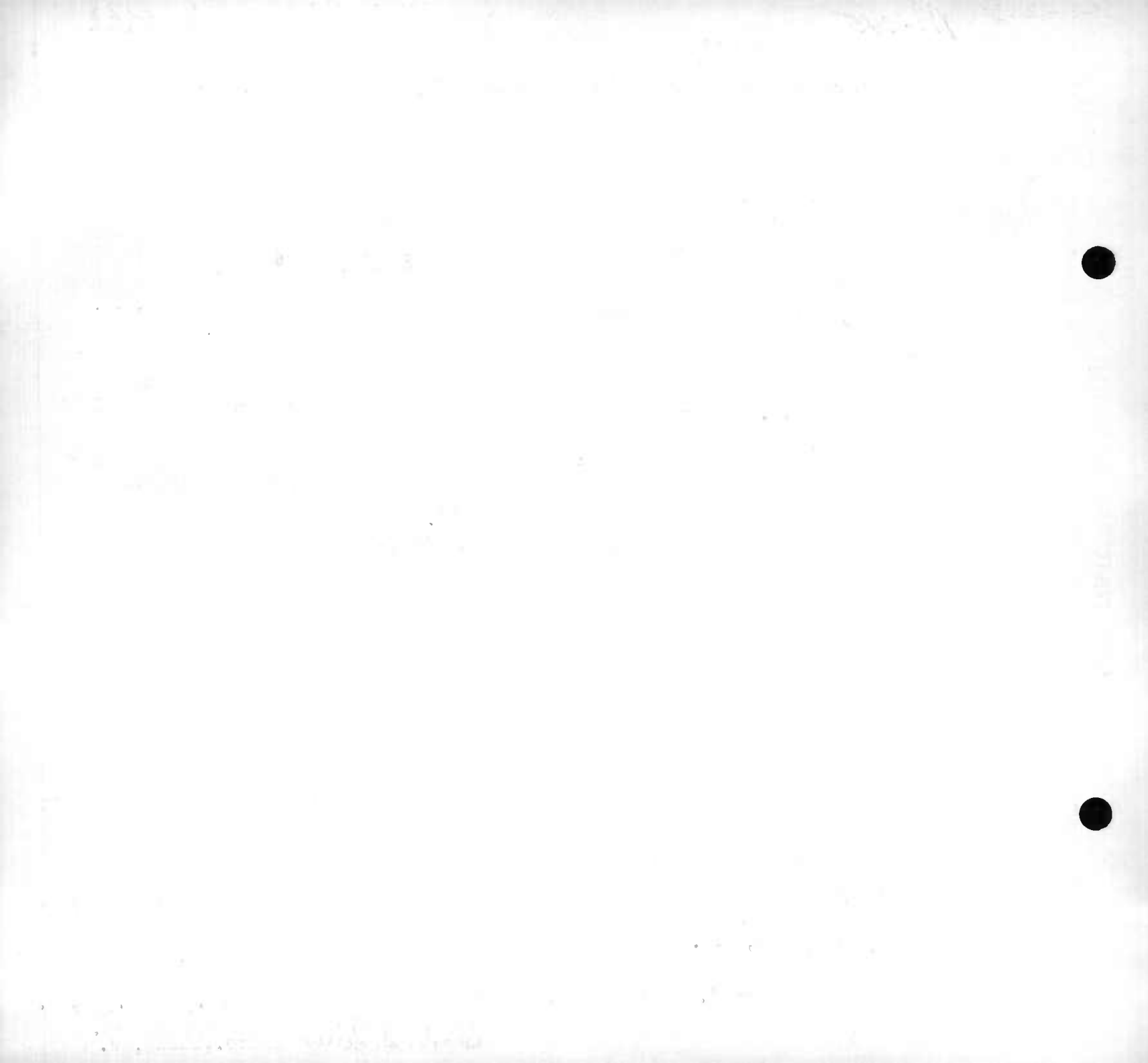
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9140</u>	
BIRTH NO. <u>D-500 71 9140</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MARY ELLEN KAILER DUNN</b>			2. DATE AND HOUR OF DEATH <b>September 30, 1971 7:10 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Long Green Nursing Home 115 E. Melrose Ave. Baltimore, Md.</b>			A. STATE <b>Md.</b> B. COUNTY <b>901</b>		
C. CITY OR TOWN <b>Baltimore</b>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>602 Cator Ave.</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3, 1886</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>House Work.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Charles Kailer</b>			14. MOTHER'S MAIDEN NAME <b>Helen Ferguson</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Charles J. Dunn : 6747 Glenkirk Rd., #21229.</b>	
18. <b>437.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypostatic pneumonia</b> (B) <b>Cerebral arteriosclerosis</b> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>2 years</b>
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Mar 19 1946</b> to <b>Sept 30 1971</b> that (I) (we) last saw the deceased alive on <b>Sept 28 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Frederick J. Volmer M.D.</b>				23B. DATE SIGNED <b>Sept 30, 1971</b>	
23C. PHYSICIAN'S NAME (Type) <b>FREDERICK J. VOLMER</b>				23D. ADDRESS <b>6100 York Rd., Balto., 21212, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-2-71.</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Frederick Ave. Balto., Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 1 1971</b>		25B. NAME OF REGISTRAR <b>Rebecca B. ...</b>		25C. FUNERAL DIRECTOR <b>William &amp; Sonce</b>	
25D. ADDRESS <b>901 S. CONKLING ST. BALTO., 21224, MD.</b>					



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 9141	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. 71 9141		2. DATE AND HOUR OF DEATH September 30, 1971 1:35 A.			
1. NAME OF DECEASED (Type or Print) Casimir Macklin (CASIMIR WALTER MACKLIN)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2605			
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7-22-15(1915)		9. AGE (In years last birthday) 56 (56)		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Michael Macklin		14. MOTHER'S MAIDEN NAME Mary Blum			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.II		16. SOCIAL SECURITY NO.		17. INFORMANT 4940 Eastern Avenue Baltimore, Maryland 21224 ADDRESS BCH: Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 5581314571.0 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Shock? sepsis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Bx sepsis hcty lumen			
(C) DUE TO, OR AS A CONSEQUENCE OF: at ankyr chly k hemorrhage					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/24 19 71 to 9/30 19 71 that (I) (we) last saw the deceased alive on 9/30 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leon Landau, M.D.		23B. DATE SIGNED September 30, 1971		23C. PHYSICIAN'S NAME (Type) Leon Landau, M.D. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-4-71.		24C. NAME of CEMETERY or CREMATORY St Stanislaus Cemetery	
24D. LOCATION 6015 Boston Ave., Balto., Md.		24E. DATE REC'D BY HEALTH DEPT. OCT 1 1971		24F. NAME OF REGISTRAR Charles J. Giller	
24G. FUNERAL DIRECTOR ADDRESS 6224 Eastern Ave. Balto., 21224, Md.		24H. DATE OF DEATH 9/30/71		24I. TIME OF DEATH 1:35 A.	

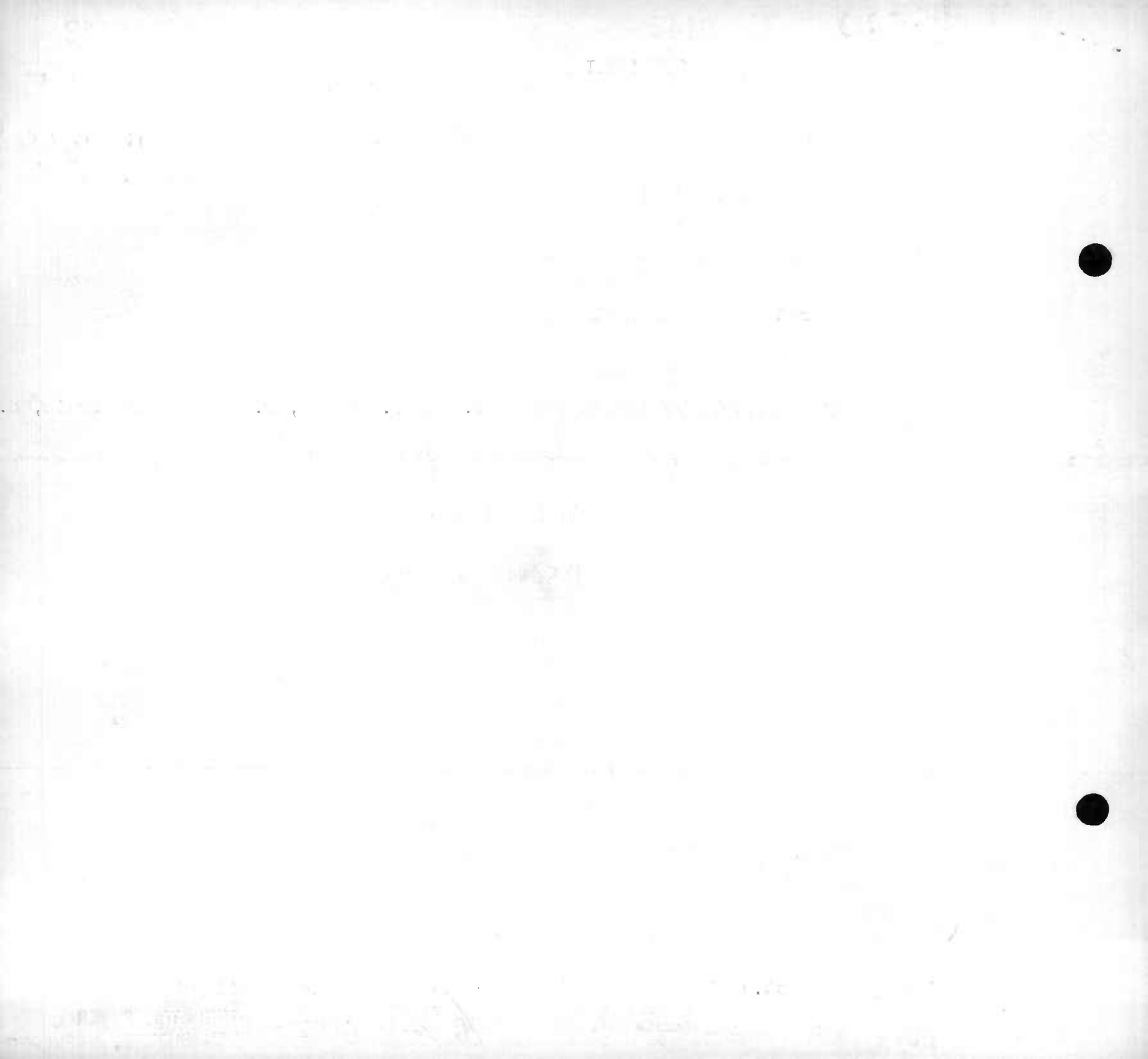




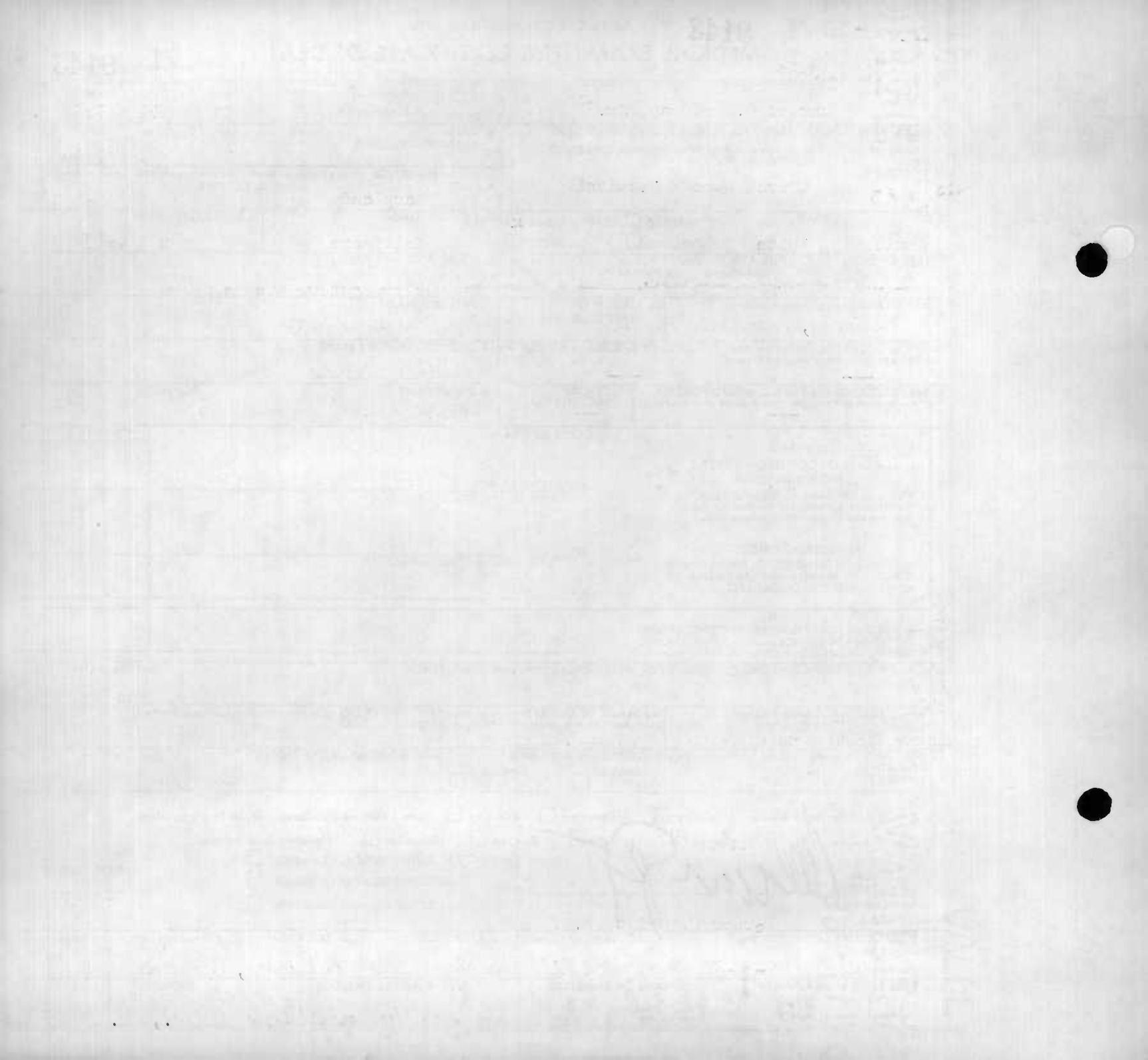
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		71 9142	
CERTIFICATE OF DEATH				REG. NO.		71 9142	
BIRTH NO. <b>K-520</b>		71 9142		2. DATE AND HOUR OF DEATH <b>9-30-71 6:40 A.M.</b>			
1. NAME OF DECEASED (Type or Print) <b>Mrs. Lottie E. Kinsey (ELIZABETH)</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Bon Secours Hospital</b>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>md</b> B. COUNTY <b>Anne Arundel</b>				5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Bon Secours Hospital</b>				C. CITY OR TOWN <b>Pasadena</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>229 Dale Rd.</b>				8. DATE OF BIRTH <b>12/5/97</b>		9. AGE (in years last birthday) <b>73</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEMAKER (ret)</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				13. FATHER'S NAME <b>George Warfield</b>			
14. MOTHER'S MAIDEN NAME <b>GEORGIA GOODHAND</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>218 48 2456</b>				17. INFORMANT <b>Mr. Leo J. Kinsey, Jr. (son) Glen Burnie, Md.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Sudden Cardiac Arrest -</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute Rt coronary thrombosis -</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <b>Dissect + ACHD</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9-20-71</b> to <b>9-30-71</b> that (I) (we) last saw the deceased alive on <b>9-30-71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Marco Flores</b>				23B. DATE SIGNED <b>9-30-71</b>		23C. PHYSICIAN'S NAME (Type) <b>MARCO FLOREZ</b>	
23D. ADDRESS <b>BON SECOURS HTL. BALTIMORE MARYLAND</b>				23E. SIGNATURE <b>MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>Oct. 4/71</b>		24C. NAME OF CEMETERY or CREMATORY <b>GLEN HAVEN MEMORIAL PARK</b>		24D. LOCATION (City, town, or county) (State) <b>GLEN BURNIE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 1 1971</b>		25B. NAME OF REGISTRAR <b>Palmer E. Jones, Jr.</b>		25C. FUNERAL DIRECTOR <b>Palmer E. Jones, Jr.</b>		ADDRESS <b>SINGLETON FUNERAL HOME GLEN BURNIE, MARYLAND</b>	



BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 71 9143			
BIRTH NO. H-155-71 9143 71-13346				1. NAME OF DECEASED (Type or Print) Charles D. Huffman, Jr.				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 9 28 71 7:40 P.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home & Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 9 28 71 7:40 P.M.				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 104			
6. SEX Male		7. RACE White		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH 8-1-71		10. AGE (In years last birthday) 1 1/2		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 2219 Eastern Avenue					
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF USA		13. FATHER'S NAME Charles Hoffman					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Diane Stevens					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO. ---		18. INFORMANT Richard Hoffman				ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 795X1				CAUSE OF DEATH (A) IMMEDIATE CAUSE SDIT DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) DUE TO, OR AS A CONSEQUENCE OF:											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
20A. DATE OF OPERATION 7				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 9-28-71											
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 9-30-71		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 1 1971				25B. NAME OF REGISTRAR Robert E. Farber, M.D.				25C. FUNERAL DIRECTOR ADDRESS 237 Patapsco Avenue McGully's Funeral Home Balto., Md. 21225			



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P-323 71 9144

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 71 9144

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES A. PADGETT		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1 E. Mt. Royal Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 27 1971 11 a M.	
6. SEX male		7. RACE white	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 8-7-12		10. AGE (In years last birthday) 57 88?	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James E. Padgett		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Molly Gwatney		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 213 01 9341		18. INFORMANT Catherine Padgett 444 Patapsco Ave. Balto., Md. 21225	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cirrhosis of liver DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTECEDENT CAUSES OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9-27-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-1-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 1 1971		25B. NAME OF REGISTRAR Robert E. Barber, M.D.	
25C. FUNERAL DIRECTOR McCully Funeral Home		ADDRESS 237 Patapsco Avenue Balto., Md. 21225	

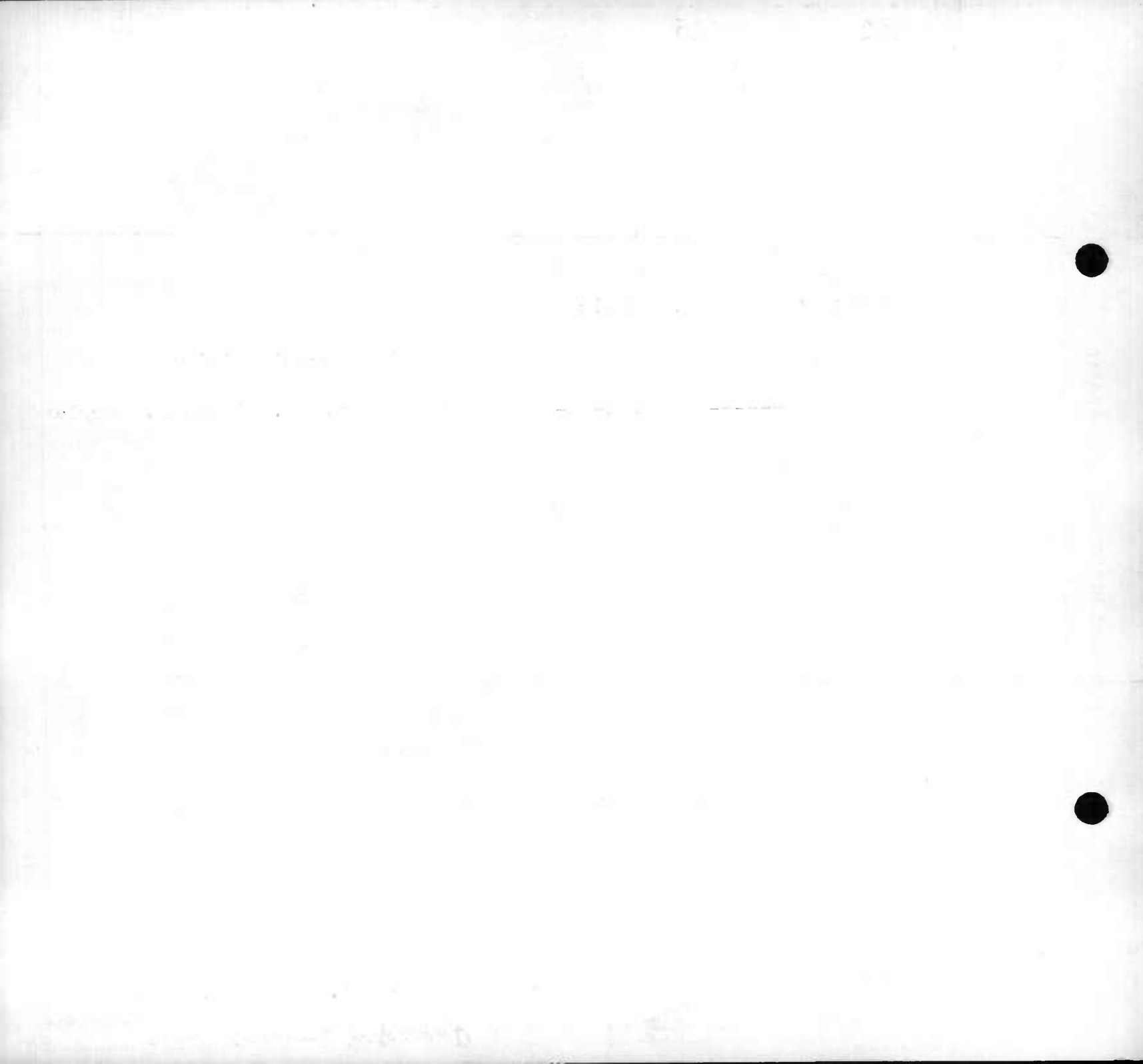
VS 151-REV. 7/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-432 71 9145		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 9145	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Fields Martha</i>		2. DATE AND HOUR OF DEATH <i>September 25, 71 7:30 p.m.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>Baltimore</i>		1537	
FULL NAME OF HOSPITAL OR INSTITUTION <i>39 Provident Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>3321 Alto Rd.</i>			
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-7-96</i>	9. AGE (in years last birthday) <i>76</i>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>		11. BIRTHPLACE (State or foreign country) <i>md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Phyllis Lucretia Fields</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-32-4502</i>		17. INFORMANT ADDRESS <i>Annie Harvey, St. Michaels, Maryland</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>412.201 250.9</i>		CAUSE OF DEATH <i>Acute pulmonary edema</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Hypertensive cardiovascular disease</i>			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Diabetes mellitus</i>					
19A. DATE OF OPERATION <i>9-25-71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9-25-71</i> to <i>9-25-71</i> that (I) (we) last saw the deceased alive on <i>9-25-71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>V. Chitraplee</i>		23B. DAYE SIGNED <i>Sep. 26, 71</i>		23C. PHYSICIAN'S NAME (Type) <i>Vadhana Chitraplee</i>	
23D. ADDRESS <i>Provident Hosp.</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/29/71</i>	
24C. NAME of CEMETERY or CREMATORY <i>Thomas Memorial Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>St. Michaels, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 1 1971</i>	
25B. NAME OF REGISTRAR <i>Robert J. ...</i>		25C. FUNERAL DIRECTOR <i>HARRISON Funeral Home</i>		25D. ADDRESS <i>St. Michaels md.</i>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department CERTIFICATE OF DEATH				REG. NO. <b>71 9146</b>	
BIRTH NO. <b>B-424 71 9146</b>					
1. NAME OF DECEASED (Type or Print) <b>SUSIE BLACKWELL</b>			2. DATE AND HOUR OF DEATH <b>Sept. 27, 1971 7:45 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>39 PROVIDENT HOSPITAL 2600 LIBERTY HEIGHTS AVENUE BALTIMORE, MARYLAND 21217</b>			4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1304</b> C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2331 BRYANT AVENUE</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-8-1894</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Store</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
13. FATHER'S NAME <b>?</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			14. MOTHER'S MAIDEN NAME <b>Ella Walker</b>		
16. SOCIAL SECURITY NO. <b>214-24-8362</b>			17. INFORMANT <b>Mrs. Marie Clapp DeMines</b> ADDRESS <b>2331 Bryant Av</b>		
18. CAUSE OF DEATH I <b>436.7 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Broncho Pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CVA</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION <b>9-27-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>SEPTEMBER 27, 19 71</b> to <b>SEPTEMBER 27, 19 71</b> that (I) (we) lost saw the deceased alive on <b>SEPTEMBER 27, 19 71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. G. Mercado</b>			23B. DATE SIGNED <b>SEPTEMBER 27, 1971</b>		
23C. PHYSICIAN'S NAME (Type) <b>M. G. MERCADO RESIDENT DONALD STEWART, M.D.</b>			23D. ADDRESS <b>PROVIDENT HOSPITAL- 2600 LIBERTY HEIGHTS</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>10-2-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Co.</b>		24E. LOCATION (State) <b>Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 1 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. J. ...</b>		25C. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME</b> ADDRESS <b>3035 W. NORTH AVE.</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 9147	
BIRTH NO. 4-400 71 9147				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ELIZABETH G. HALL			2. DATE AND HOUR OF DEATH 9-30-71 4:55 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Proident Hospital Baltimore, Md.			C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX Female 6. RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 6/15/91 9. AGE (In years last birthday) 80		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nurse maid 10B. KIND OF BUSINESS OR INDUSTRY Pvt family			11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frank Hall			14. MOTHER'S MAIDEN NAME Annie Grayson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Mrs. Eunice B. Hall			ADDRESS 3227 Gwynns Falls		
18. 157.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Pancreas		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			none		
19A. DATE OF OPERATION June 1971 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED see 18 (A)			20A. AUTOPSY? (Yes or No) no		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 8/9 1971 to 9/30 1971 that (I) (we) last saw the deceased alive on 9/30 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D. W. STEWART, M.D.			23B. DATE SIGNED 9/30/71		
23C. PHYSICIAN'S NAME (Type) D. W. STEWART, M.D.			23D. ADDRESS 2300 Garrison Blvd.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-4-71		24C. NAME of CEMETERY or CREMATORY St. Joseph's Cemetery	
24D. LOCATION Texas		24E. LOCATION Maryland		24F. LOCATION	
25A. DATE REC'D BY HEALTH DEPT. OCT 1 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR NUTTER, FUNERAL HOME	
25D. ADDRESS 3035 W. NORTH AVE		25E. ADDRESS		25F. ADDRESS	



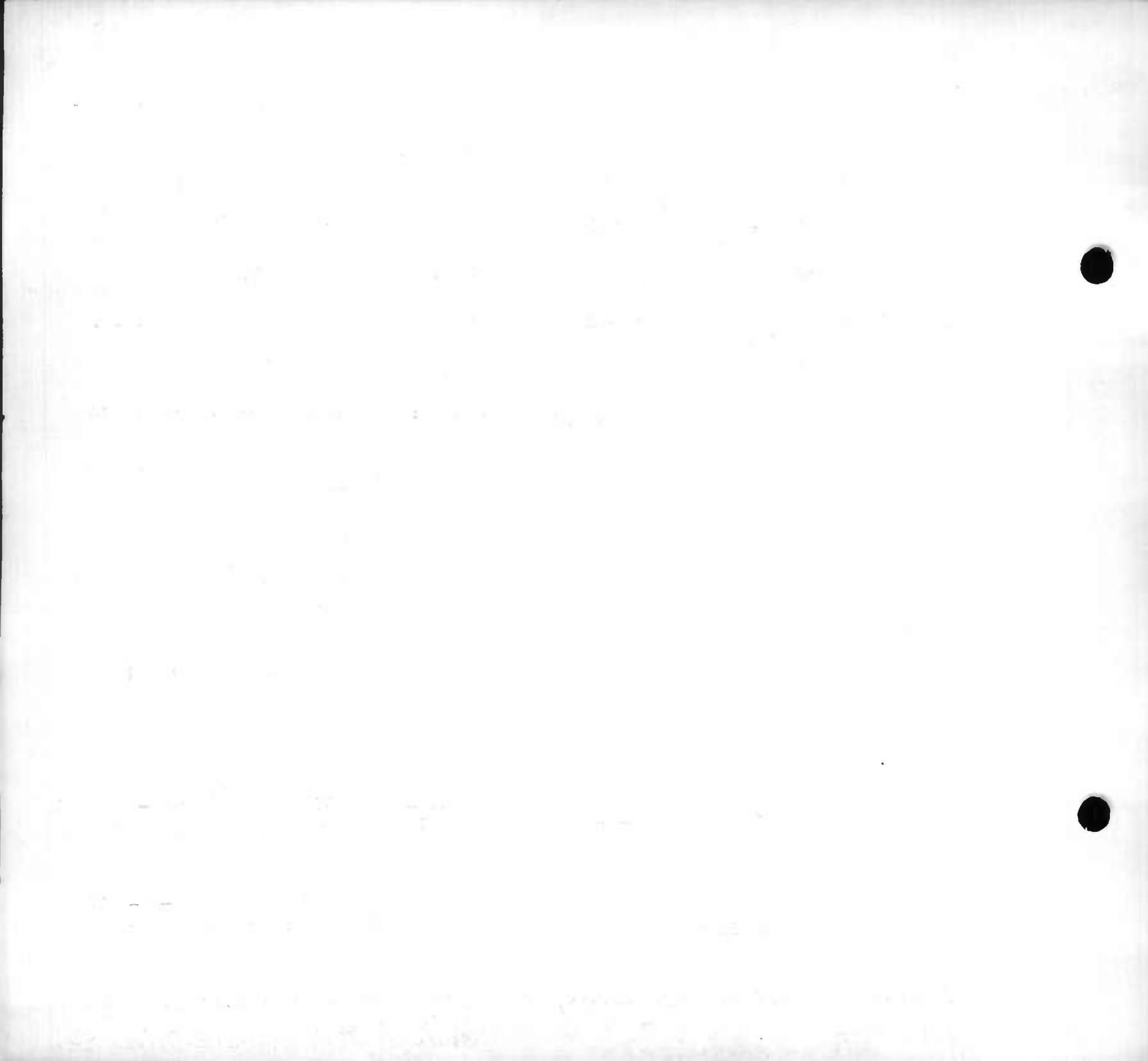
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>Emma Maxine Dorsey</u>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <u>9</u> Day <u>29</u> Year <u>71</u> Hour <u>11:10</u> a. <u>M.</u>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>2111 Garrison Blvd.</u>				3. DATE PRONOUNCED DEAD Month <u>9</u> Day <u>29</u> Year <u>71</u> Hour <u>11:10</u> a. <u>M.</u>			
				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1548</u>			
6. SEX <u>female</u>	7. RACE <u>Negro</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <u>12-14-1931</u>		10. AGE (in years lost birthday) <u>39</u>		E. STREET AND NUMBER <u>2111 Garrison Blvd.</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF <u>USA</u>		13. FATHER'S NAME <u>Howard S. Dorsey Sr.</u>			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dept. of Agriculture</u>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <u>Pauline S. Dickerson</u>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		17. SOCIAL SECURITY NO. <u>218-28-8847</u>		18. INFORMANT <u>Mrs. Pauline S. Young</u> ADDRESS <u>4637 Park Hts.</u>			
19. <u>57181</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH <u>Hyperthermia complicating fatty metamorphosis of liver</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <u>yes</u>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Unk.</u>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Unk.</u>			
22D. TIME OF INJURY (APPROX.) Month <u>Unk.</u> Day <u>Unk.</u> Year <u>Unk.</u> Hour <u>Unk.</u>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> <u>Unk.</u> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <u>Unk.</u>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>  ACTUAL SIGNATURE <u>Ronald N. Kornblum</u> M.D. EXAMINER'S NAME (Type) <u>Ronald N. Kornblum, MD</u>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <u>9/29/71</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-4-1971</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 1 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME</u> ADDRESS <u>3035 W. NORTH AV</u>			

Letter from M.E.'s office 10-27-71 M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9149</u>	
P-400 71 9149				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		POWELL, KATIE		September 27, 1971 8:30 AM. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			A. STATE Maryland C. CITY OR TOWN Baltimore E. STREET AND NUMBER 1207 Luzerne Ave 21223		
5. SEX Female			6. RACE Negro		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 3/26/94		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10B. KIND OF BUSINESS OR INDUSTRY At Home		
13. FATHER'S NAME Esau			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. NONE		
17. INFORMANT Records: BCH-4940 Eastern Avenue 21224			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 445.91 Cerebrovascular accident Pneumonia			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 71 mo		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Possible Septicemia			71 mo		
(B) DUE TO, OR AS A CONSEQUENCE OF: gangrene of Rt foot			71 mo		
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-18-19 71 to 9-27-19 71 that (I) (we) lost saw the deceased alive on 9-27-19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Surat Sinasa, M.D.				23B. DATE SIGNED 9-27-1971	
23C. PHYSICIAN'S NAME (Type) SURAT SINASA M.D.				23D. ADDRESS 4940 Eastern Avenue, 21224 Baltimore City Hosp., Baltimore, Md	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-30-71		24C. NAME OF CEMETERY OR CREMATORY Mt. CALVARY CEMETERY	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR Anne Arundel Co., Md. 243 E. Oliver St.			
25A. DATE REC'D BY HEALTH DEPT. OCT 1 1971		25B. NAME OF REGISTRAR Ralph J. Collick		25C. ADDRESS	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John <del>Federowicz</del> Federowicz		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> 9 30 71 5:45 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 317 S. Durham		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 30 71 5:45 p.m.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 10/7/12		10. AGE (In years lost birthday) 58	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		14B. KIND OF BUSINESS OR INDUSTRY Merchant Marine	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 219-05-0794	
18. INFORMANT Mrs. Dorothy Zelenka, 24 S. Castle St.		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Epilepsy Acute Bronchopneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 10/4/71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) yes	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/4/71	
24C. NAME OF CEMETERY or CREMATORY Holy Rosary		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 Eastern Ave		ADDRESS	

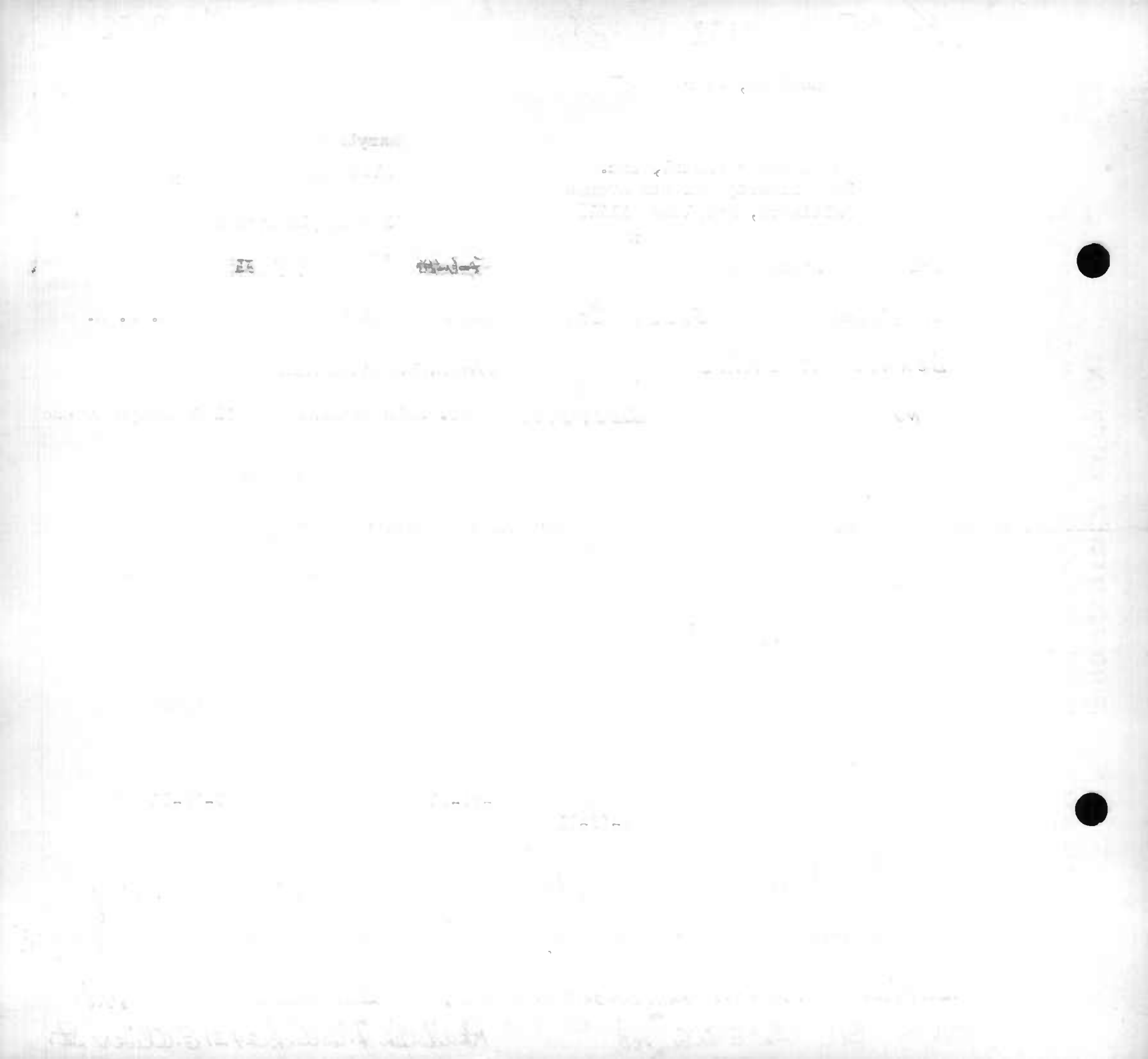
1-13-1972 - Letter from - Office of the Chief Medical Examiner, Peter Lipkovic, M.D. (abw)  
Assistant Medical Examiner

HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 9151	
CERTIFICATE OF DEATH				REG. NO. 71 9151	
BIRTH NO. <u>H-625 71 9151</u>		1. NAME OF DECEASED (Type or Print) <u>Hopkins, John</u>			
2. DATE AND HOUR OF DEATH <u>9/29/71</u> <u>9:20</u> P.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>39</u> <u>Provident Hospital, Inc.</u> <u>2600 Liberty Heights Avenue</u> <u>Baltimore, Maryland 21215</u>			
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1548</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2304 Roslyn Avenue</u>		5. SEX <u>Male</u> 6. RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>5-3-1894</u>		9. AGE (in years last birthday) <u>77</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Dennis Hopkins</u>	
14. MOTHER'S MAIDEN NAME <u>Hannah Mitchell</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-27-8901</u>	
17. INFORMANT <u>Mr. John Hopkins</u>		ADDRESS <u>2304 Roslyn Avenue</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Broncho pneumonia</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Congestive Heart Failure</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Severe malnutrition &amp; dehydration</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>9-27-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-27-71</u> 19 to <u>9-29-71</u> 19 that (I) (we) last saw the deceased alive on <u>9-29-71</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Manuel G. Mercado</u>		23B. DATE SIGNED <u>9/29/71</u>		23C. PHYSICIAN'S NAME (Type) <u>MANUEL G. MERCADO MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-4-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1971</u>		25B. NAME OF REGISTRAR <u>Randolph J. Collick</u>	
25C. FUNERAL DIRECTOR <u>2431 E. Oliver St.</u>		25D. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH										
REG. NO.					71 9152					
BIRTH NO. <span style="float: right;">S-530 71 9152</span>										
1. NAME OF DECEASED (Type or Print) <u>Jane Smith</u>					2. DATE AND HOUR OF DEATH <u>9/28/71</u> <u>8 P. M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>607 Pennsylvania Ave</u> <u>George Washington Nursing Home</u>					A. STATE <u>md.</u>					
					B. COUNTY <u>1511</u>					
C. CITY OR TOWN <u>BALT. more</u>					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
					E. STREET AND NUMBER					
5. SEX <u>71</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/30/80</u>	9. AGE (In years last birthday) <u>91</u>	If Under 1 Yr. Months: Days: Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Unknown</u>			12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. <u>216-56-3423 A</u>			17. INFORMANT <u>Chart</u>				ADDRESS			
18. <u>250.91</u> CAUSE OF DEATH										
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Diabetes Mellitus</u>										
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <u>Generalized Arteriosclerosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Senile Dementia</u>										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (1) (this hospital) attended the deceased from <u>9-28-71</u> to <u>9-28-71</u> that (1) (we) lost saw the deceased alive on <u>9-28-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Richard Tyson, M.D.</u>					23B. DATE SIGNED <u>9-28-71</u>			23C. PHYSICIAN'S NAME (Type) <u>Dr. R. F. Tyson</u>		
23D. ADDRESS <u>936 W. North Ave</u>					23E. CITY, TOWN, OR COUNTY <u>Baltimore, Maryland</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>10/4/71</u>			24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
25A. NAME OF REGISTRAR <u>John E. ...</u>					25B. FUNERAL DIRECTOR <u>...</u>					
25C. ADDRESS <u>...</u>					25D. ADDRESS <u>...</u>					

Adm 8/3/71

3205 Sequoia Ave.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">71 9153</span>
BIRTH NO. <span style="float: right;">U-425 71 9153</span>		1. NAME OF DECEASED (Type or Print) <i>Wilson, Montell</i>		
2. DATE AND HOUR OF DEATH <i>9/27/71 12:35 a.m.</i>		M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Provident Hospital</i>		A. STATE <i>Baltimore</i> B. COUNTY <i>1501</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>2600 Liberty Heights</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>MALE</i> 6. RACE <i>NEGRO</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-24-06</i> 9. AGE in years (lost birthday) <i>55</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>216-10-6654</i>		17. INFORMANT <i>Mrs. Lorraine Covington (Daughter)</i>
18. <i>5717</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CIRRHOSIS of the Liver</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>September 17, 1971</i> to <i>September 27, 1971</i> and that (I) (we) lost saw the deceased alive on <i>September 27, 1971</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>M. Mercado</i> M. D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>27 Sept. '71</i>
23C. PHYSICIAN'S NAME (Type) <i>M. G. MERCADO</i> M.D.		23D. ADDRESS <i>Provident Hosp. Balto MD 21215</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/3/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cemetery</i>
24D. LOCATION (City, town, or county) (State) <i>A A County Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 4 1971</i>		
25B. NAME OF REGISTRAR <i>Adolphus Halstead</i>		25C. FUNERAL DIRECTOR <i>1206 NORTH Ave</i>		

100-100000

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100-100000



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 9154	
T-460				71 9154	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SADIE TAYLOR		Sept. 29, 1971		2:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
LUTHERAN HOSPITAL OF MARYLAND. 46		MARYLAND		1702	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		2922 ARUNAH AVE			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months Days
F	NEGRO	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	3-2-98	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
				U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.		Cerebral Vascular Accident		24 hrs	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Generalized Arteriosclerosis		10 years	
		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Intertrochanteric Fracture, Left Femur		36 days	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
8/27/71	Fracture of Femur				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
	Nursing Home	2922 ARUNAH AVE.			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
8-23-71	While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	slipped & fell			
22. I certify that (I) (this hospital) attended the deceased from 8-23-1971 to 9-29-1971 that (I) (we) lost saw the deceased alive on 9-29-1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
William B. Russell, M.D.		9/29/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
William B. Russell, M.D.		LUTHERAN HOSPITAL OF MARYLAND.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	10/2/71	Mt. Calvary Cemetery	A A County Md		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
OCT 4 1971	Rebecca L. Wadsworth	Pholpus D. Walstead		1206 W North Ave	

Adm. 3/25/70

954 Stoddard Ct.

B-32071

9155

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

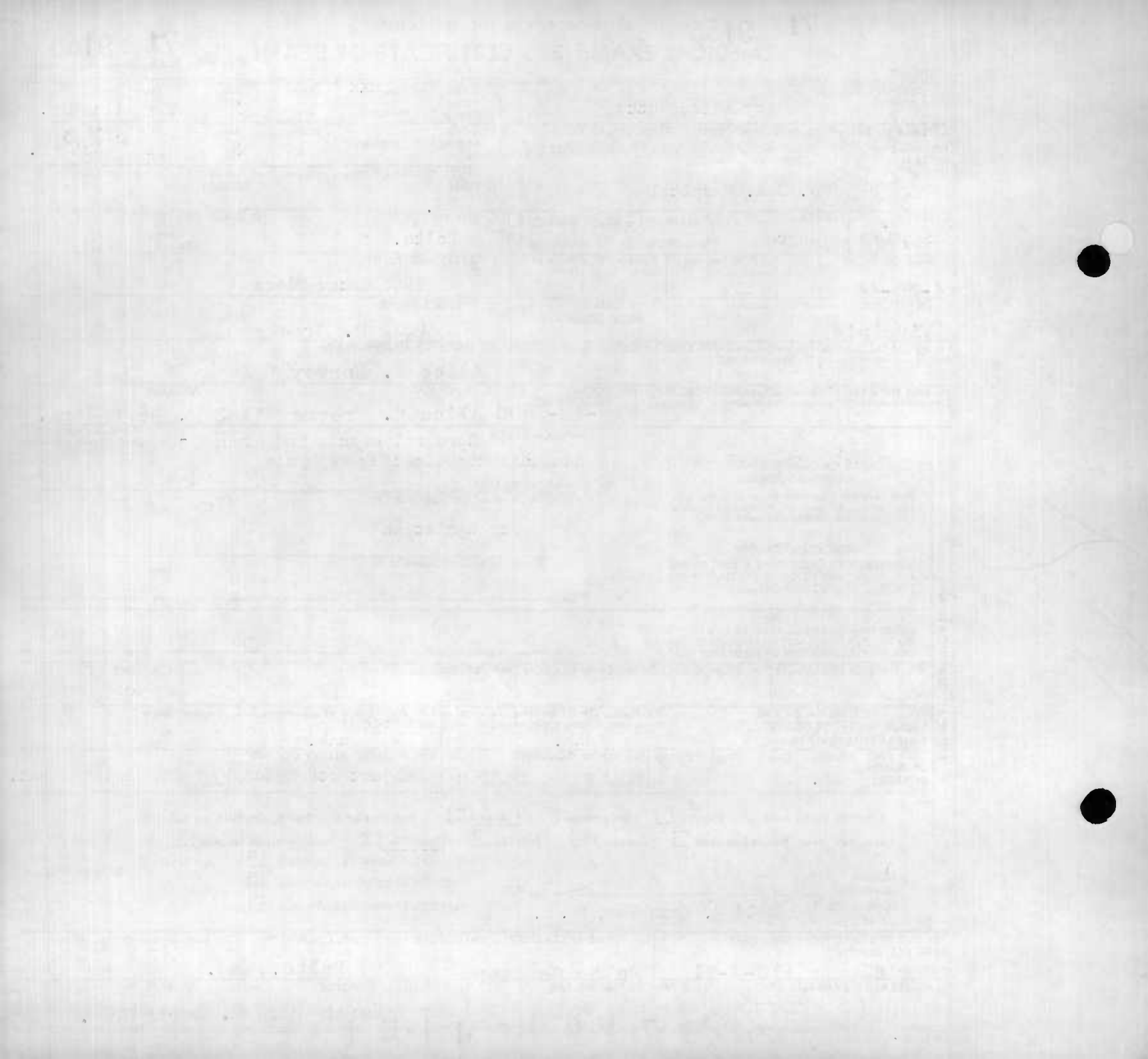
REG. NO.

71

9155

BIRTH NO.

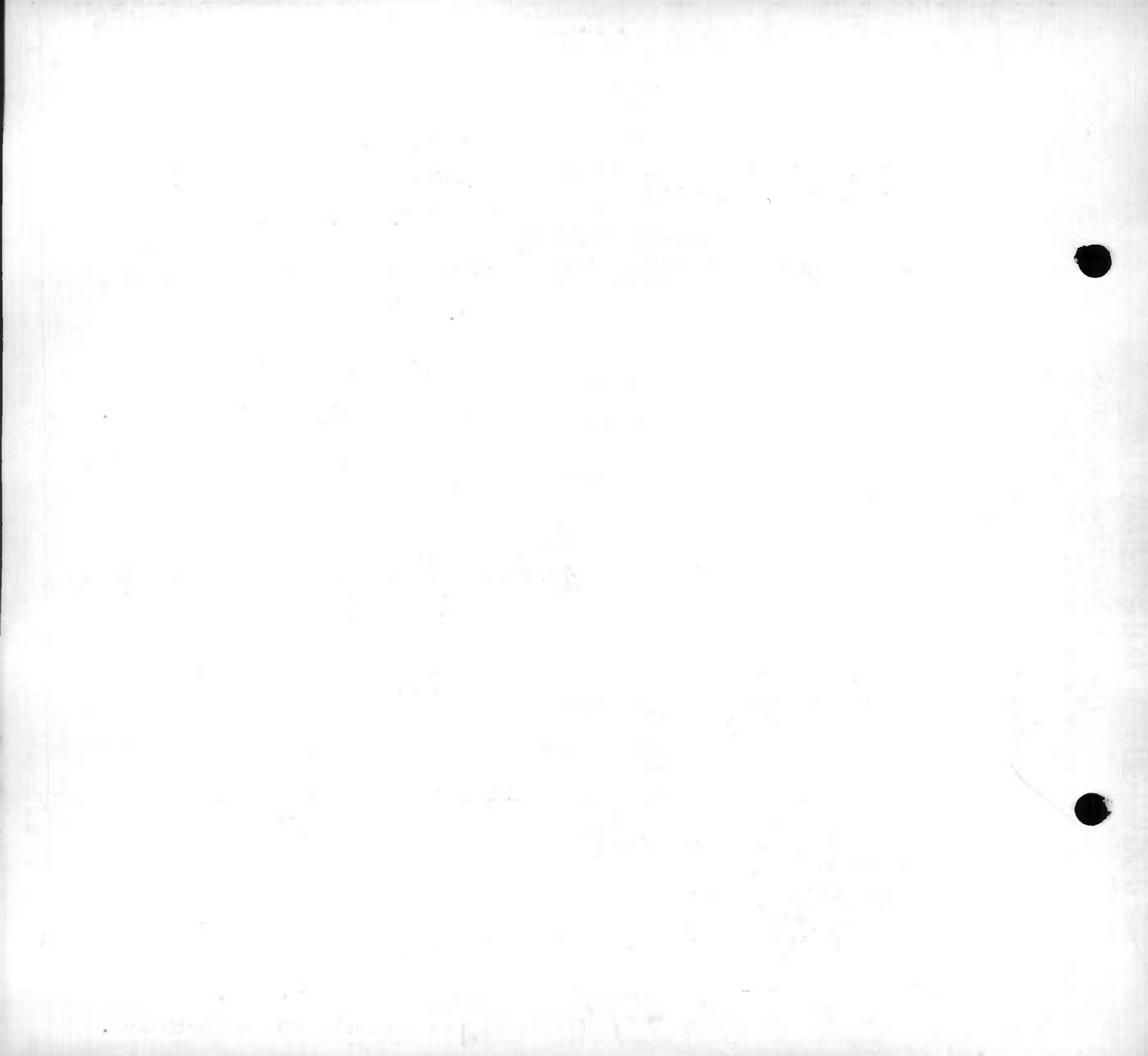
1. NAME OF DECEASED (Type or Print) Mary Alice Butts		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 10 3 71 1:00 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Md. Gen. Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 3 71 1:00 a.m.	
6. SEX female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 4-30-46		10. AGE (In years lost birthday) 25	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Alice E. Harvey	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 216-48-3208	
18. INFORMANT Alice E. Greene		ADDRESS 1103 E. North Ave.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E963X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cerebral anoxia and broncho-pneumonia complicating asphyxia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) unk.	
22C. WHERE DID INJURY OCCUR? unk.		22F. HOW DID INJURY OCCUR? Subject strangled by unknown assailant.	
22D. TIME OF INJURY (APPROX.) un.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-7-71	
24C. NAME of CEMETERY or CREMATORY Balto Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1971		25B. NAME OF REGISTRAR Robert E. Harvey, M.D.	
25C. FUNERAL DIRECTOR Wm C March		ADDRESS 928 E. North Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9156</u>
BIRTH NO. <u>S-530 71 9156</u>		1. NAME OF DECEASED (Type or Print) <u>Lorraine Smith</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>October 1, 1971</u> <u>7:40</u> P. M.		
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u> BALTIMORE, MD 21205		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1203</u>		
5. SEX <u>FEMALE</u>		6. RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH <u>03-29-44</u>		9. AGE (In years last birthday) <u>27</u>
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY
13. FATHER'S NAME <u>WILLIAM SMITH</u>		14. MOTHER'S MAIDEN NAME <u>AUSTRALIA WILLIAMS</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Candiesas Smith 4409 Haden Ave.</u>
18. <u>5-81-X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Septic Shock</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Thrombocytopenic purpura + Sickle cell</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>4 yrs</u> <u>27 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<u>Congestive Heart Failure</u>		
19A. DATE OF OPERATION <u>2 6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 28</u> 19 <u>71</u> to <u>Oct 1</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Oct 1</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>George J. Taylor</u>		23B. DATE SIGNED <u>10-1-71</u>		23C. PHYSICIAN'S NAME (Type) <u>George J. Taylor</u>
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>10-5-71</u>		24C. NAME OF CEMETERY OF CREMATORY <u>Mt Auburn Cemetery</u>
24D. LOCATION <u>Balto., Md.</u>		25A. DECEASED BY NAME OF DEATH <u>OCT 4 1971</u>		
25B. NAME OF REGISTRAR <u>John C. March</u>		25C. FUNERAL DIRECTOR <u>John C. March</u>		
25D. ADDRESS <u>928 E North Ave.</u>				



BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or print)

Lexie (Lexis) Jones Jr

2. DATE OF DEATH

Known ☒ Estimated ☐ Month 10 Day 1 Year 71 Hour 6:45 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 3002 Harford Road

3. DATE PRONOUNCED DEAD

Month 10 Day 1 Year 71 Hour 6:45 p.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Md. B. COUNTY 906

6. SEX

male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

3-4-34

10. AGE (In years last birthday)

37

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3002 Harford Road

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Lexie H. Jones

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Sanitation Worker

14B. KIND OF BUSINESS OR INDUSTRY

Balto City

15. MOTHER'S MAIDEN NAME

Adell Lawson

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

212-32-5898

18. INFORMANT

ADDRESS

Ruth Williams 1907 E. 31st Street

19.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Intravenous narcotism

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)  
yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/2/71

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-6-71

24C. NAME OF CEMETERY or CREMATORY

Balto Cemetery

24D. LOCATION (City, town, or county) (State)

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

OCT 4

1971

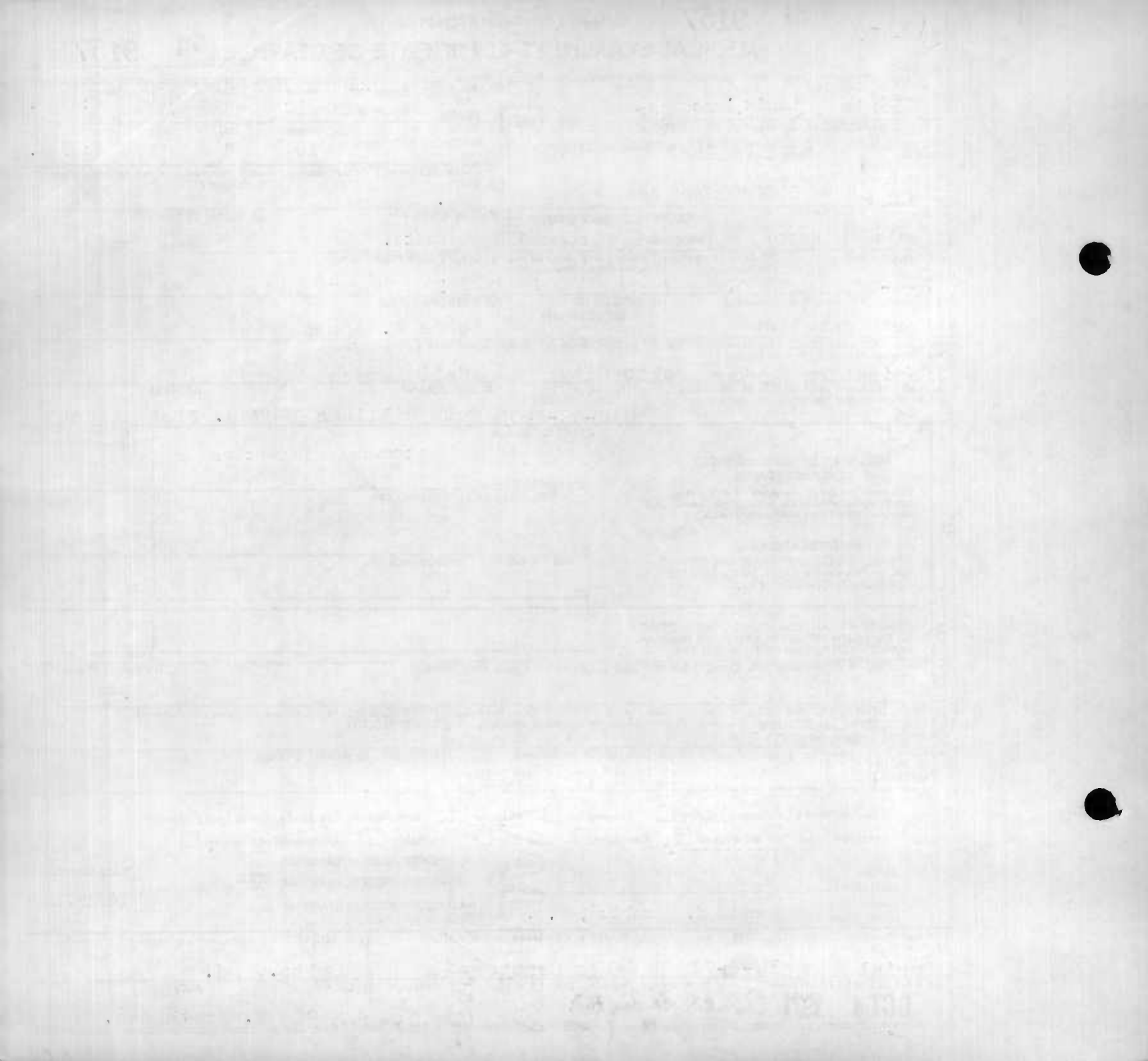
25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Wm. C. Marsh 928 E. North Ave.

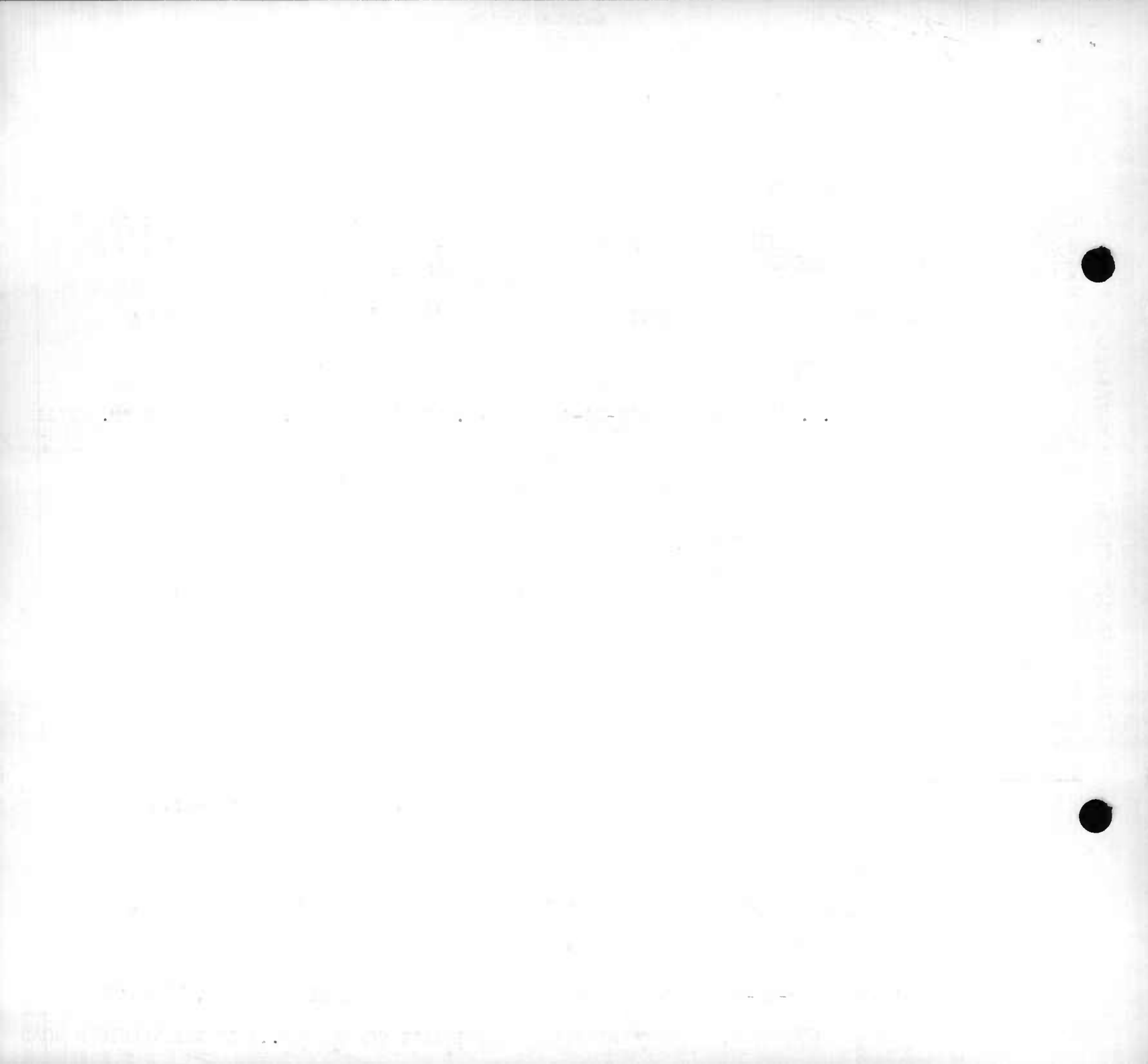




FUNERAL DIRECTOR: IMPORTANT

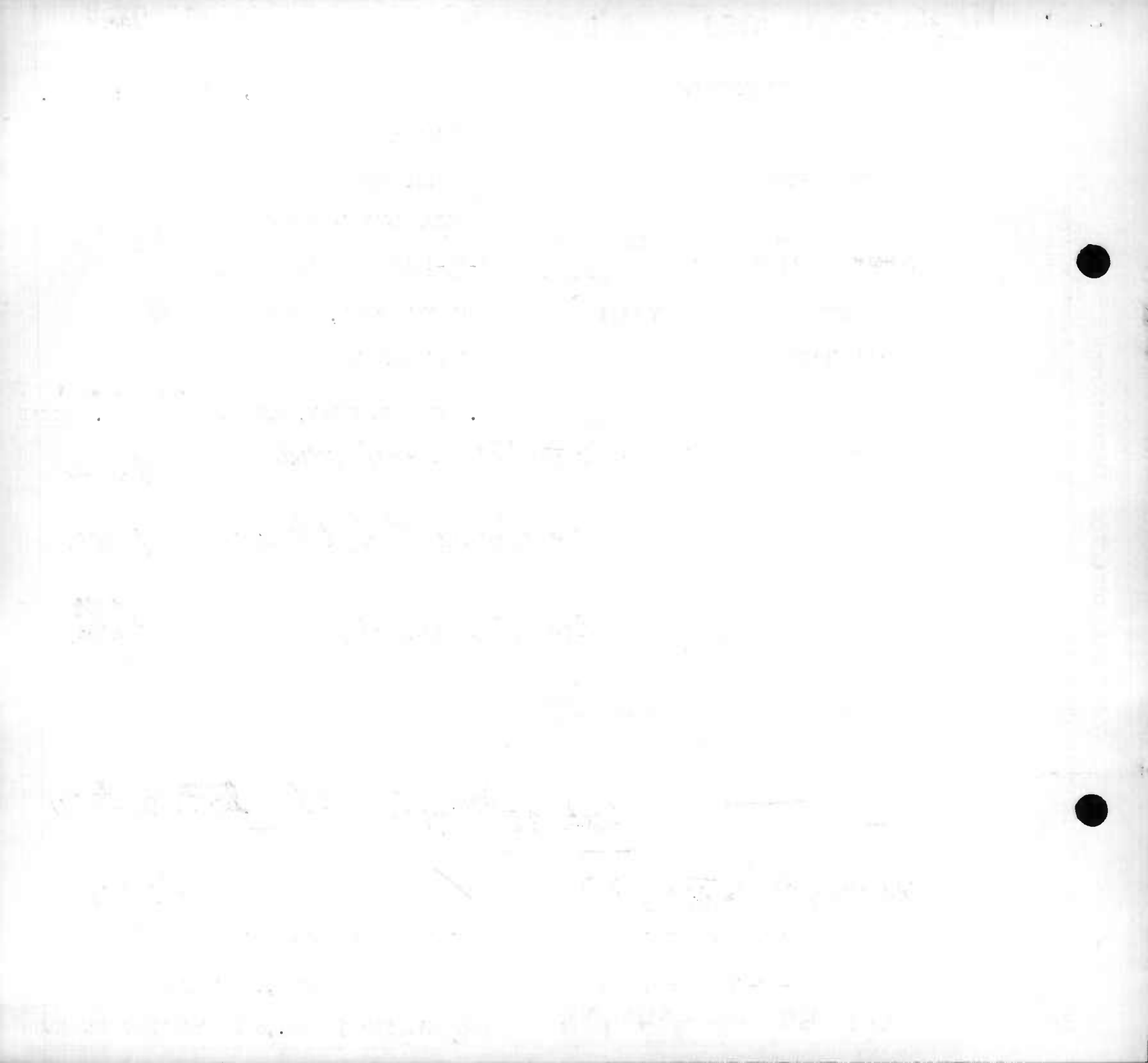
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9158</u>	
7-635 <u>71 9158</u>					
BIRTH NO. <u>71 9158</u>		1. NAME OF DECEASED (Type or Print) <u>FRIEDMAN, PHILIP</u>			
2. DATE AND HOUR OF DEATH <u>9/29/71 1:05 P.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u>		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL</u> <u>42</u>			
C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>6940 BLANCHE RD.</u>		<u>71215</u>			
5. SEX <u>Male</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/20/04</u>	9. AGE (in years last birthday) <u>66</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUTTER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>MEATS</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u> <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>SIMON FRIEDMAN</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES <u>W.W. II ARMY</u>		16. SOCIAL SECURITY NO. <u>577-24-8641</u>		17. INFORMANT ADDRESS <u>MRS. ETHEL FRIEDMAN, 6940 BLANCHE RD. #21215</u>	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>CARDIO-RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>HYPOXEMIA</u> DUE TO, OR AS A CONSEQUENCE OF: <u>PNEUMONIA + PULMONARY INSUFFICIENCY</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>9/23/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/23/71</u> 19 <u>71</u> to <u>9/29/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/29</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Anacleto T. Ordinario</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9/29/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>ANACLETO T. ORDINARIO, M.D.</u>		23D. ADDRESS <u>SINAI HOSP. of BALTIMORE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-30-71</u>		24C. NAME of CEMETERY or CREMATORY <u>PETACH TIKVAH</u>	
24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>			



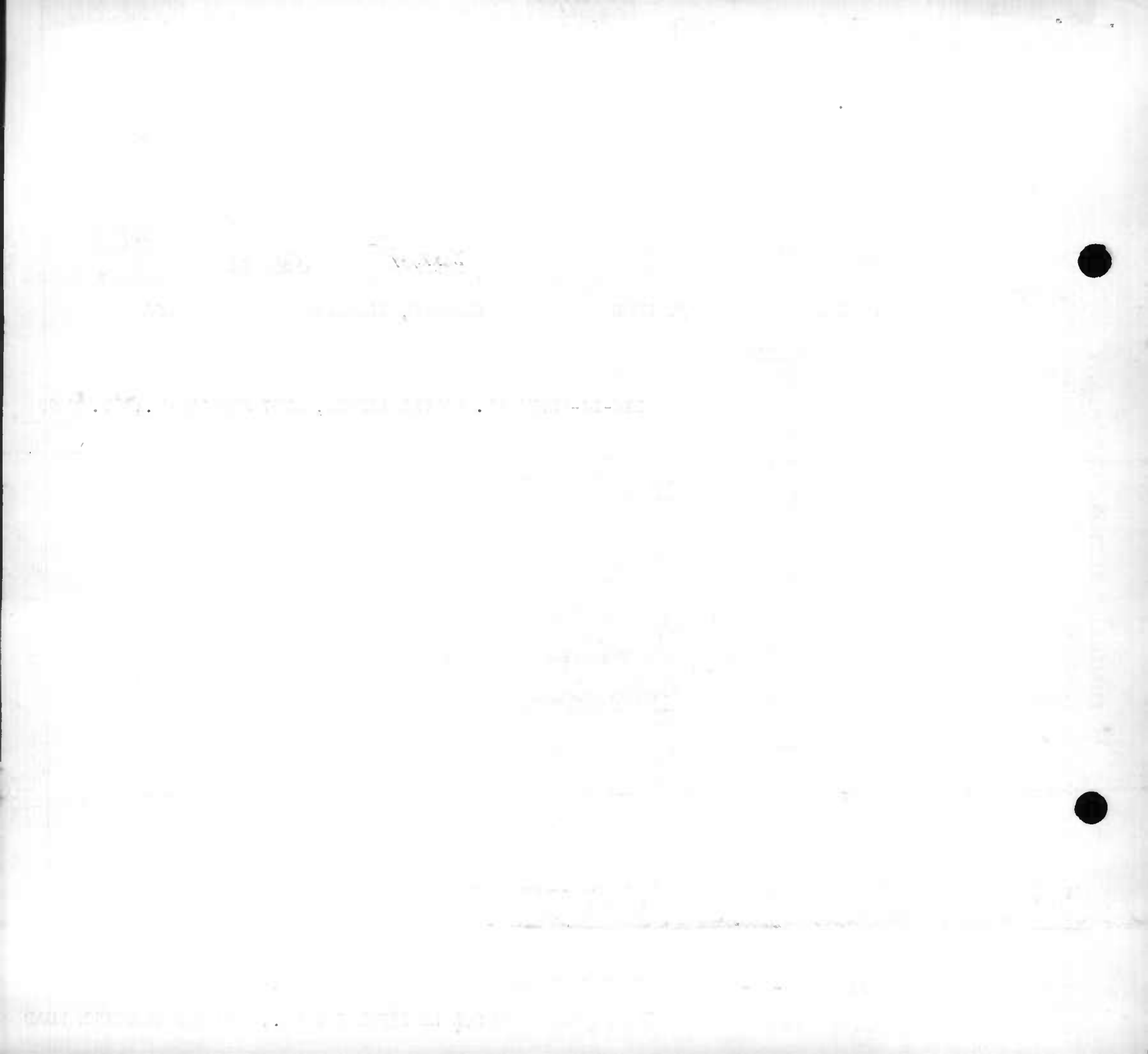
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">71 9159</span>
BIRTH NO. <span style="float: right;">Z-63271 9159</span>		1. NAME OF DECEASED (Type or Print) <span style="float: right;">CELIA ZERITSKY</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <span style="float: right;">SEPTEMBER 28, 1971   7:56 P. M.</span>		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="float: right;">SINAI HOSPITAL</span>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <span style="float: right;">MARYLAND</span> B. COUNTY <span style="float: right;">2831</span>		
CITY OR TOWN <span style="float: right;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <span style="float: right;">4235 LABYRINTH ROAD</span>				
5. SEX <span style="float: right;">FEMALE</span>	6. RACE <span style="float: right;">WHITE</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="float: right;">8-30-1915</span>	9. AGE (In years last birthday) <span style="float: right;">56</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">HOUSEWIFE</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="float: right;">AT HOME</span>		11. BIRTHPLACE (State or foreign country) <span style="float: right;">NEW YORK CITY, NEW YORK</span>
12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">USA</span>		13. FATHER'S NAME <span style="float: right;">JOSEPH JOFFE</span>		
14. MOTHER'S MAIDEN NAME <span style="float: right;">LENA ALBERT</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="float: right;">NO</span>		
16. SOCIAL SECURITY NO.		17. INFORMANT <span style="float: right;">MR. DAVID ZERITSKY, 4235 LABYRINTH RD. #21215</span>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="float: right;">metastatic carcinoma</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="float: right;">6 mos.</span>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="float: right;">Carcinoma of left breast</span>		DUE TO, OR AS A CONSEQUENCE OF: <span style="float: right;">9 mos.</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="float: right;">Diabetes mellitus</span>		<span style="float: right;">3 yrs.</span>		
19A. DATE OF OPERATION <span style="float: right;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">Jan. 18, 1968</span> to <span style="float: right;">September 28, 1971</span> that (I) (we) last saw the deceased alive on <span style="float: right;">Sept. 28, 1971</span> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <span style="float: right;">Marvin Goldstein, M.D.</span>		23B. DATE SIGNED <span style="float: right;">9/30/71</span>		
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">MARVIN GOLDSTEIN</span>		23D. ADDRESS <span style="float: right;">6001 PARK HEIGHTS AVENUE</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">BURIAL</span>	24B. DATE <span style="float: right;">9-30-71</span>	24C. NAME of CEMETERY or CREMATORY <span style="float: right;">OHLE YAKOV</span>	24D. LOCATION (City, town, or county) (State) <span style="float: right;">BALTIMORE, MARYLAND</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">OCT 4 1971</span>		25B. NAME OF REGISTRAR <span style="float: right;">SOL LEVINSON</span>		
25C. FUNERAL DIRECTOR <span style="float: right;">BROS., 6010 REISTERSTOWN ROAD</span>		ADDRESS		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.	
G-651 71 9161		71 9161		71 9161	
1. NAME OF DECEASED (Type or Print) <b>Jacob H. Greenfeld</b>		2. DATE AND HOUR OF DEATH <b>September 30, 1971 12 Noon M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 House in the Pines Belvedere 2525 W. Belvedere Avenue Baltimore, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>(6301 Shelrick Dr. (21209))</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> E. STREET AND NUMBER <b>6301 Shelrick Dr. 21209</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/2/08</b>	9. AGE (In years lost birthday) <b>63</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHARMICIST</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>American USA</b>		13. FATHER'S NAME <b>Simon Greenfeld</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Lipsitz</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-32-3570</b>		17. INFORMANT <b>MRS. NAN GREENFIELD, 6301 SHELICK DR.</b> ADDRESS <b>6301 SHELICK DR. BALTIMORE, MARYLAND</b>	
18. <b>427.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Cerebral Anoxia</b> <b>Radio-Respiratory Arrest</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Anoxia</b> (C) <b>Radio-Respiratory Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 DAYS</b> <b>7 WKS.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>9/29</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/29</b> 19 <b>71</b> to <b>9/30</b> 19 <b>71</b> , that (I) <b>last</b> saw the deceased alive on <b>9/29</b> 19 <b>71</b> and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>did</b> (did not) view the body after death.					
23A. SIGNATURE <b>Raymond F. Caplan, MD</b>		23B. DATE SIGNED <b>9/30/71</b>		23C. PHYSICIAN'S NAME (Type) <b>Raymond F. Caplan, MD</b>	
23D. ADDRESS <b>1010 St. Paul St.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			
24B. DATE <b>10-1-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>LUBAWITZ</b>		24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	

BALTIMORE, MARYLAND

DATE

TELEPHONE

RECEIVED

1912-12-12

BALTIMORE, MARYLAND

DATE

TELEPHONE

RECEIVED



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>W-214</u>				BALTIMORE CITY HEALTH DEPARTMENT				71 9162				71 9162			
BIRTH NO.				CERTIFICATE OF DEATH				REG. NO.							
1. NAME OF DECEASED (Type or Print) <b>NATHAN WEISBLATT</b>								2. DATE AND HOUR OF DEATH <b>SEPTEMBER 29, 1971 5:20P.M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL</b> <b>42</b>								4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2788</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5345 CUTHBERT AVENUE #21215</b>							
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-11-1905</b>		9. AGE (In years last birthday) <b>66</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHIPPING DEPT. MANAGER</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>WHOLESALE SHOES</b>				11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>RABBI M. N. WEISBLATT</b>								14. MOTHER'S MAIDEN NAME <b>HANNAH ?</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>								16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS <b>MRS. ANN WEISBLATT, 5345 CUTHBERT AVE. #21215</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>5-years</b>								CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertension heart disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>None</b> (C) <b>None</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
								OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>None</b>							
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>No</b>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>May 1</b> 19 <b>66</b> to <b>Sept 29</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>Sept 29</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.												23A. SIGNATURE <b>Manuel Levin</b>		23B. DATE SIGNED <b>9/29/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>MANUEL LEVIN</b>								23D. ADDRESS <b>6101 PARK HEIGHTS AVENUE</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>10-1-71</b>				24C. NAME of CEMETERY or CREMATORY <b>WORKMEN CIRCLE</b>				24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1971</b>				25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>				25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>							

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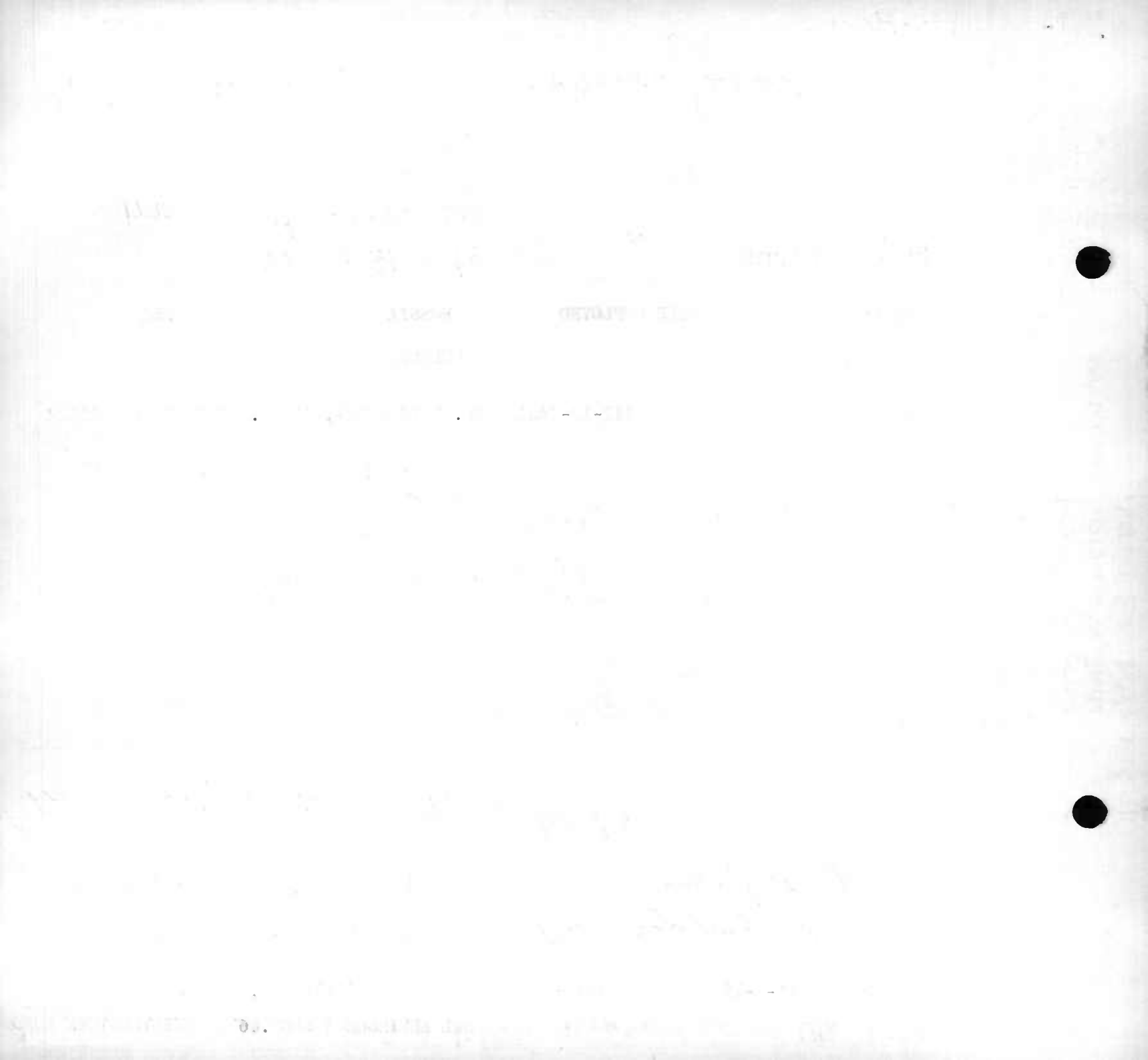
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 9163</b>	
BIRTH NO. <b>5-300 71 9163</b>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>SCOTT, ARTHUR</b>			2. DATE AND HOUR OF DEATH <b>9/29/71 7:21 p. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL 42</b>			A. STATE <b>MD</b> B. COUNTY <b>2610</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>425 North East Av. 21224</b>		
5. SEX <b>Male</b>	6. RACE <b>W HITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/14/1885</b>	9. AGE (In years last birthday) <b>86</b>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAILOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>212-12-2431A</b>		17. INFORMANT ADDRESS <b>MRS. ETTA SCOTT, 425 N. EAST AVENUE #21224</b>			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiopulmonary arrest 30'</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>① Acute M.I. ② CHF</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>③ Bilateral bronchopneumonia</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/22/71</b> to <b>9/29/71</b> that (I) (we) lost saw the deceased alive on <b>9/29/71</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>K. Michaelides</b>				23B. DATE SIGNED <b>9/29/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>K. Michaelides MD</b>				23D. ADDRESS <b>SINAI HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-1-71</b>		24C. NAME of CEMETERY or CREMATORY <b>MIKRO KODESH</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1971</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SQL LEVINSON &amp; BROS. 46010 REISTERSTOWN ROAD</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 9164</b>	
H-455		71 9164		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		VICTOR HILEMAN		9-27-71 12:15 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  33 THE JOHNS HOPKINS HOSPITAL				A. STATE MARYLAND	
				B. COUNTY 2609	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1119 S. BAYLIS ST.	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03-01-98	9. AGE (In years lost birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) BALTO MD	
13. FATHER'S NAME SOL HILEMAN				14. MOTHER'S MAIDEN NAME SARAH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 218-07-0781		17. INFORMANT Mrs Florence Feinberg	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). COPD w/o ulcer disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 27 1971 to Sept 27 1971 that (I) (we) last saw the deceased alive on Sept 27 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John A. Nesbitt, III MD				23B. DATE SIGNED Sept. 27, 1971	
23C. PHYSICIAN'S NAME (Type) JOHN A. NESBITT 3RDM.D.				23D. ADDRESS 601 N. Broadway	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		Sept 30 1971		GETTYSBURG NATIONAL CEMETERY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 4 1971		Robert E. Taylor, R.D.		Joseph M. Fanning	
				ADDRESS 263 S. Connellys	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>M-625 71 9165</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: flex-end;"> <span>REG. NO. 71 9165</span> </div>	
BIRTH NO. _____	
1. NAME OF DECEASED (Type or Print) <b>PEARL H. MORGAN</b>	
2. DATE AND HOUR OF DEATH <b>Oct. 1, 1971 11:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 CHURCH HOME + HOSPITAL</b>	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>USA</b>	
C. CITY OR TOWN <b>BALTO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3120 ST. Paul St.</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>9/24/91</b>	
9. AGE (In years last birthday) <b>80</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS HUSON</b>	
14. MOTHER'S MAIDEN NAME <b>LAURA WEAVER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____	
16. SOCIAL SECURITY NO. <b>213204132</b>	
17. INFORMANT <b>John T. Morgan</b> ADDRESS <b>Balto. Md.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Renal Shutdown</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Recurrent urinary bleeding</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF: CA, urinary bladder</b> <b>(C) Diabetes Mellitus, possible acute</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>undetermined</b> <b>undetermined</b> <b>undetermined</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes Mellitus, possible acute</b>	
19A. DATE OF OPERATION <b>10/1/71</b>	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) _____	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? _____	
22. I certify that <del>he</del> (this hospital) attended the deceased from <b>9/25</b> 19 <b>71</b> to <b>10/1</b> 19 <b>71</b> that <del>he</del> (we) last saw the deceased alive on <b>10/1</b> 19 <b>71</b> and that <del>in</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>He</del> (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>W. Maniago M.D.</b>	
23B. DATE SIGNED <b>10/1/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>WILMA B. MANIAGO M.D.</b>	
23D. ADDRESS <b>CH 11</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>10/4/71</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1971</b>	
25B. NAME OF REGISTRAR <b>Robert J. Johnson</b>	
25C. FUNERAL DIRECTOR <b>William E. Johnson</b> ADDRESS <b>Balto. Md.</b>	

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## References



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9166</u>	
G-416 BIRTH NO. <u>71 9166</u>		71 9166		71 9166	
1. NAME OF DECEASED (Type or Print) <u>Julia Wm Glover</u>			2. DATE AND HOUR OF DEATH <u>Sept 28 1971</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u> <u>43</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <u>Md.</u>	
				B. COUNTY	
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>529 North Charles</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19, 1892</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>retail</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William B. Ware</u>		14. MOTHER'S MAIDEN NAME <u>Ida Ridgely</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Harold W. Reinhardt 800 S. Milken Ave</u>	
18. <u>4124 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner <u>None</u> )		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(H)</del> (this hospital) attended the deceased from _____ 19 _____ to <u>Sept 28</u> 19 <u>71</u> that <del>(H)</del> (we) lost saw the deceased alive on <u>Sept 28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>(H)</del> (We) <del>(did)</del> (did not) view the body after death.					
23A. SIGNATURE <u>H. E. Bondy</u>				23B. DATE SIGNED <u>9-29-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>H. E. Bondy</u>				23D. ADDRESS <u>Key Circle Hospice</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/1/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Olivet</u>	
24D. LOCATION <u>Baltimore</u>		<u>City</u>		<u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>William E. Johnson</u>	
				ADDRESS <u>Balto. Md</u>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>K-632 71 9167</b>		BALTIMORE CITY HEALTH DEPARTMENT		Register No. <b>71 9167</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>MARY FRANCES KRATZ</b>			2. DATE AND HOUR OF DEATH <b>September 30, 1971 5:30 P. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 Ardleigh Nursing Home 2095 Rockrose Avenue</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>401</b> CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>111 West Mulberry Street</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Never Married</b>	8. DATE OF BIRTH <b>July 30, 1886</b>	9. AGE (In years lost birthday) <b>85</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Fred Kratz</b>			14. MOTHER'S MAIDEN NAME <b>Frances Ryan</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	17. INFORMANT ADDRESS <b>Agnes Trier 27A Norph Dean Av. Trenton N. J.</b>		
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cerebral arteriosclerosis with senile changes</b> DUE TO III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>3 yrs.</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 16, 1970</b> to <b>September 30, 1971</b> , that (I) (we) last saw the deceased alive on <b>September 22, 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Lloyd E. Saylor M.D.</b>				23B. DATE SIGNED <b>Oct. 1, 1971</b>	
23C. PHYSICIAN'S NAME (Type) <b>Lloyd E. Saylor</b>			23D. ADDRESS M.D. <b>3902 Greenmount Avenue</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/2/71</b>	24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore City, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1971</b>		25B. NAME OF REGISTRAR <b>William E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>8521 Loch Raven Blvd.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9168</u>	
<div style="display: flex; justify-content: space-between;"> <span>S-350 71 9168</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Elizabeth Stahm		September 27, 1971 8:30 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
00 805 South Streeper Street		Maryland 101			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		805 South Streeper Street			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birth day)	10. KIND OF BUSINESS OR INDUSTRY
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	April 22, 1887	84	Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Husband: ADDRESS	
No		216-05-5690-B		Mr. Rudolph Stahm 805 South Streeper Street Baltimore, Maryland 21224	
18. <u>4-12-41</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Arteriosclerotic Cardio-vascular			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Disease			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Oct. 4</u> 19 <u>67</u> to <u>Sept. 27</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Aug. 3</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
<i>Clarence W. LeDoux</i>		9/29/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Clarence W. LeDoux, M.D.		3023 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	10-1-71	Gardens of Faith	Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
OCT 4 1971	<i>John J. Duda</i>	John J. Duda 2829 Hudson St. Balto. Md. 21224			



## CERTIFICATE OF DEATH

REG. NO.

71 9169

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Claire Beaudriault

2. DATE AND HOUR OF DEATH

9/29/71

12<sup>10</sup> A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, If institution's residence before admission)

A. STATE

B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

3430 Louth Road

21222

5. SEX

Female

6. RACE

White

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

8-1-93

9. AGE (In years last birthday)

78

10. Under 1 Yr. Months: Days:

11. Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

New Hampshire

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Napoleon Dube

14. MOTHER'S MAIDEN NAME

Rose

Delphine Couture

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

216-58-4813J

17. INFORMANT

4940 Eastern Avenue  
BCH: RECORDS Baltimore, Maryland 21224

18. 423X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

5 min

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Valvular heart disease

19A. DATE OF OPERATION

9/28

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Tampoonade

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At Work ☐ Not White At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/28 1971 to 9/29 1971 that (I) (we) last saw the deceased alive on 9/29 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Michael C Finn M.D.

Attending Phys. ☒Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

9/29/71

23C. PHYSICIAN'S NAME (Type)

MICHAEL C FINN M.D.

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

10-2-71

24C. NAME OF CEMETERY or CREMATORY

Loudon Park

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE RECD BY HEALTH DEPT

OCT 4 1971

25B. NAME OF REGISTRAR

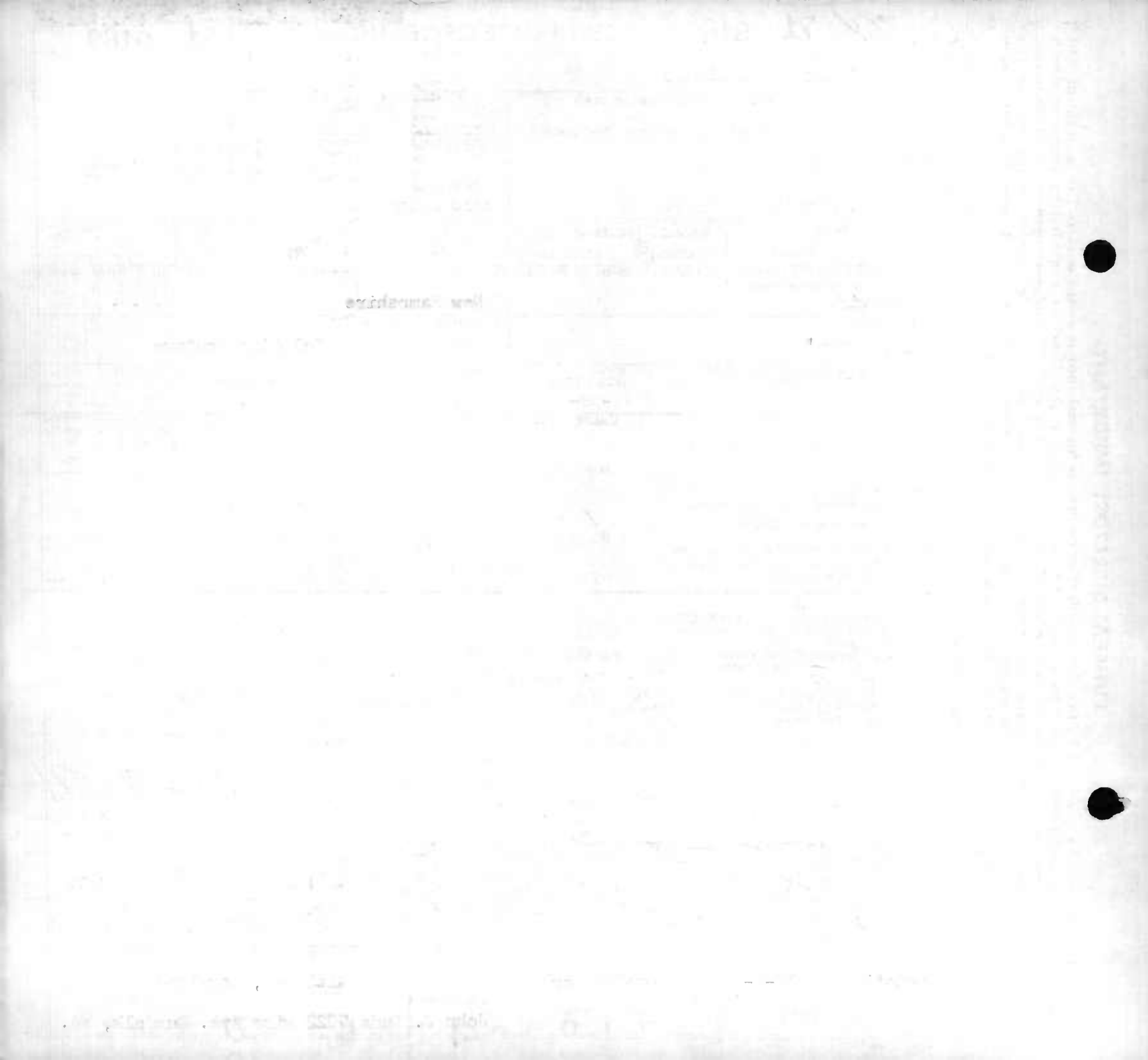
John J. Duda

25C. FUNERAL DIRECTOR

John J. Duda 7922 Wise Ave. Dundalk, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.5em;">71 9170</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">K-425 71 9170</span>		<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Klasmcier, Audrey Blanche</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.2em;">BON SECOURS HOSPITAL</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">09-29-71 7:10 P.M.</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span>		<b>6. RACE</b> <span style="font-size: 1.2em;">White</span>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">House work</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Own Home</span>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">03-16-19</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">LUTHER T. BOCKELMANN</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">STALLINGS</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">52</span>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">212-09-0314</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">CHART - BON SECOURS HOSPITAL</span>	
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <div style="text-align: center;">II</div> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">4 DAYS</span>	
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">9-22-71</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">POSSIBLE VENTRICULAR OBSTRUCTION</span>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">NO</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">None</span>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (X) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">September 15, 1971</span> <b>to</b> <span style="font-size: 1.2em;">September 29, 1971</span> <b>that (X) (we) lost</b> <span style="font-size: 1.2em;">saw</span> <b>the deceased alive on</b> <span style="font-size: 1.2em;">September 28, 1971</span> <b>and that (in (my) (our) opinion death occurred on the date</b> <span style="font-size: 1.2em;">and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.</span>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Thien Thitivarana</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">September 29, 71</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">THIEN THITIVARANA</span>		<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">BON SECOURS HOSPITAL</span>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">10/2/71</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Loudon Park Cemetery</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Balto, Maryland</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">OCT 4 1971</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">R. J. J. J. J.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">R. J. J. J. J.</span>		<b>ADDRESS</b> <span style="font-size: 1.2em;">1328 Sulphur Sp. Rd</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9171</u>	
BIRTH NO. <u>H-520</u>		71 9171			
1. NAME OF DECEASED (Type or Print) <u>Helen A. Hennick</u>			2. DATE AND HOUR OF DEATH <u>October 1, 1971</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hospital</u>			A. STATE <u>Maryland</u> B. COUNTY <u>1307</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>3740 Roland Avenue 21211</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>XX 7/2/98</u>	9. AGE (In years last birthday) <u>73 yrs.</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>- -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Garrett</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. <u>- -</u>			
16. SOCIAL SECURITY NO. <u>214-38-8707</u>		17. INFORMANT ADDRESS <u>Mr. Chas. Bennett 3107 Glenmore Ave 21214</u>			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			A. IMMEDIATE CAUSE <u>Acute Myocardial Infarct</u> <u>1 hr</u>		
			B. DUE TO, OR AS A CONSEQUENCE OF: <u>Generalized Arteriosclerosis</u> <u>10 yrs</u>		
			C. DUE TO, OR AS A CONSEQUENCE OF: <u>Arterio Sclerotic Cardiovascular disease</u> <u>6 yrs</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>N/A</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>December</u> 19 <u>70</u> to <u>October 1</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Sept 16</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Calvin F. Fuhrmann M.D.</u>				23B. DATE SIGNED <u>10/2/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>CALVIN F. FUHRMANN</u>				23D. ADDRESS <u>U.S. PHS Hospital Baltimore MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/4/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. J. J. J.</u>		25C. FUNERAL DIRECTOR <u>Donovan Funeral Home 3818 Roland Ave</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">71 9172</span>
BIRTH NO. <span style="float: right;">H-655 71 9172</span>				
1. NAME OF DECEASED (Type or Print) <span style="float: right;">DORIS HORMAN</span>		2. DATE AND HOUR OF DEATH <span style="float: right;">9/28/71 4 25 A.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="float: right;">UNIV. MD HOSPITAL 38</span>		A. STATE <span style="float: right;">MARYLAND</span> B. COUNTY <span style="float: right;">USA</span>		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <span style="float: right;">BALTIMORE</span> D. INSIDE CITY LIMITS? <span style="float: right;">YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></span>		
		E. STREET AND NUMBER <span style="float: right;">118 S. COLLINS AVE.</span>		
5. SEX <span style="float: right;">FEMALE</span>	6. RACE <span style="float: right;">WHITE</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="float: right;">10/13/51</span>	9. AGE (In years last birthday) <span style="float: right;">19</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">Student</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="float: right;">MARYLAND</span>
13. FATHER'S NAME <span style="float: right;">Austin S. Horman</span>		14. MOTHER'S MAIDEN NAME <span style="float: right;">CAROLINE REIBLICH</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <span style="float: right;">MOTHER</span> ADDRESS <span style="float: right;">118 S. Collins Ave.</span>
18. <span style="float: right;">7428</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH <span style="float: right;">RESPIRATORY FAILURE</span>		
18. <span style="float: right;">7428</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="float: right;">CEREBRAL EDEMA, Hematoma</span>		
18. <span style="float: right;">7428</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(B) DUE TO, OR AS A CONSEQUENCE OF: <span style="float: right;">A-V MALFORMATION brain</span>		
18. <span style="float: right;">7428</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(C) <span style="float: right;">A-V MALFORMATION brain</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <span style="float: right;">19/24; 9/27</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="float: right;">BRAIN A-V MALFORMATION</span>		20A. AUTOPSY? (Yes or No) <span style="float: right;">YES</span>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">9/30</span> 19 <span style="float: right;">71</span> to <span style="float: right;">9/28</span> 19 <span style="float: right;">71</span>		that (II) (we) last saw the deceased alive on <span style="float: right;">9/28</span> 19 <span style="float: right;">71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <span style="float: right;">J. A. Soliman MD</span>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="float: right;">9/28/71</span>
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">JOSEPH A. SOLIMAN MD</span>		23D. ADDRESS <span style="float: right;">UNIV. MD HOSP.</span>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <span style="float: right;">10/1/1971</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="float: right;">Mount View Cemetery</span>
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">10/1/1971</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="float: right;">Mount View Cemetery</span>
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">10/1/1971</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="float: right;">Mount View Cemetery</span>
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">10/1/1971</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="float: right;">Mount View Cemetery</span>
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">10/1/1971</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="float: right;">Mount View Cemetery</span>
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">10/1/1971</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="float: right;">Mount View Cemetery</span>
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">10/1/1971</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="float: right;">Mount View Cemetery</span>
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BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WOODROW C. ELZA

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1630 N. Calvert Street

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

September 30, 1971 11:50 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

1205

6. SEX

Male

7. RACE

White

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

Oct. 28, 1928

10. AGE (In years  
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1630 N. Calvert St.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JULIUS ELZA, SR.

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

MACHINIST

14B. KIND OF BUSINESS OR INDUSTRY

SHIPYARD

15. MOTHER'S MAIDEN NAME

SUSIE HYNSON

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW 11

17. SOCIAL  
SECURITY NO.

219 20 9566

18. INFORMANT

ADDRESS Glen Burnie

Mr. Julius H. Elza, Jr. (brother) Maryland

19. 571.9

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Massive alimentary tract hemorrhage

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Cirrhosis of liver

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

(Partial)  
Yes22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ASSISTANT MEDICAL EXAMINER ☒EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

ASSOCIATE MEDICAL EXAMINER ☐

September 30, 1971

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Oct. 2, 1971

24C. NAME of CEMETERY or CREMATORY

Lorraine Park Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

OCT 4 1971

25B. NAME OF REGISTRAR

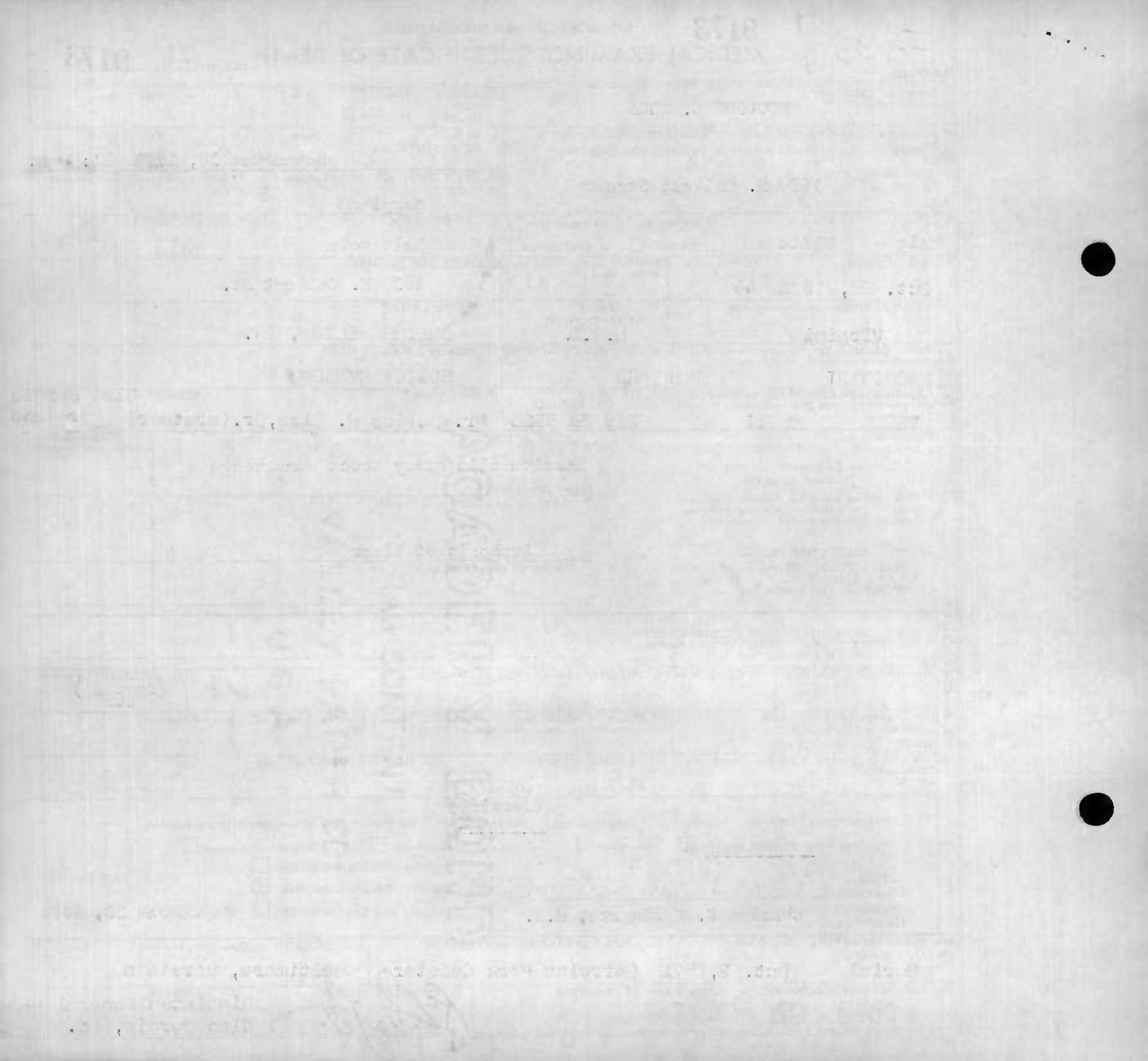
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

R. E. Taylor

ADDRESS

Singleton Funeral Home  
Glen Burnie, Md.





BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>BRENDA L. DONITHAN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 4625 Freedom Way</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 27 1971 10:20 am</b>	
6. SEX <b>female</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>white</b>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2653</b>	
9. DATE OF BIRTH <b>DEC. 15, 1950</b>		10. AGE (In years lost birthday) <b>20</b>	
11. BIRTHPLACE (State or foreign country) <b>md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MISCELLANEOUS</b>		15. MOTHER'S MAIDEN NAME <b>MILDRED MARR</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>213-60-5662</b>	
18. INFORMANT (MOTHER) <b>MILDRED M. DONITHAN</b>		ADDRESS <b>212-13 CLAREWAY - CITY</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Intravenous narcotism</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>304.9</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic</b> M.D. EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9-27-71</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/28/1971</b>	
24C. NAME OF CEMETERY or CREMATORY <b>OAK LAWN</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. CO., MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley, Jr.</b>	
25C. FUNERAL DIRECTOR <b>W. Parker Talley, Jr., Baltimore, Md.</b>		ADDRESS	

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VALLEY PAPERS

U.S.A.

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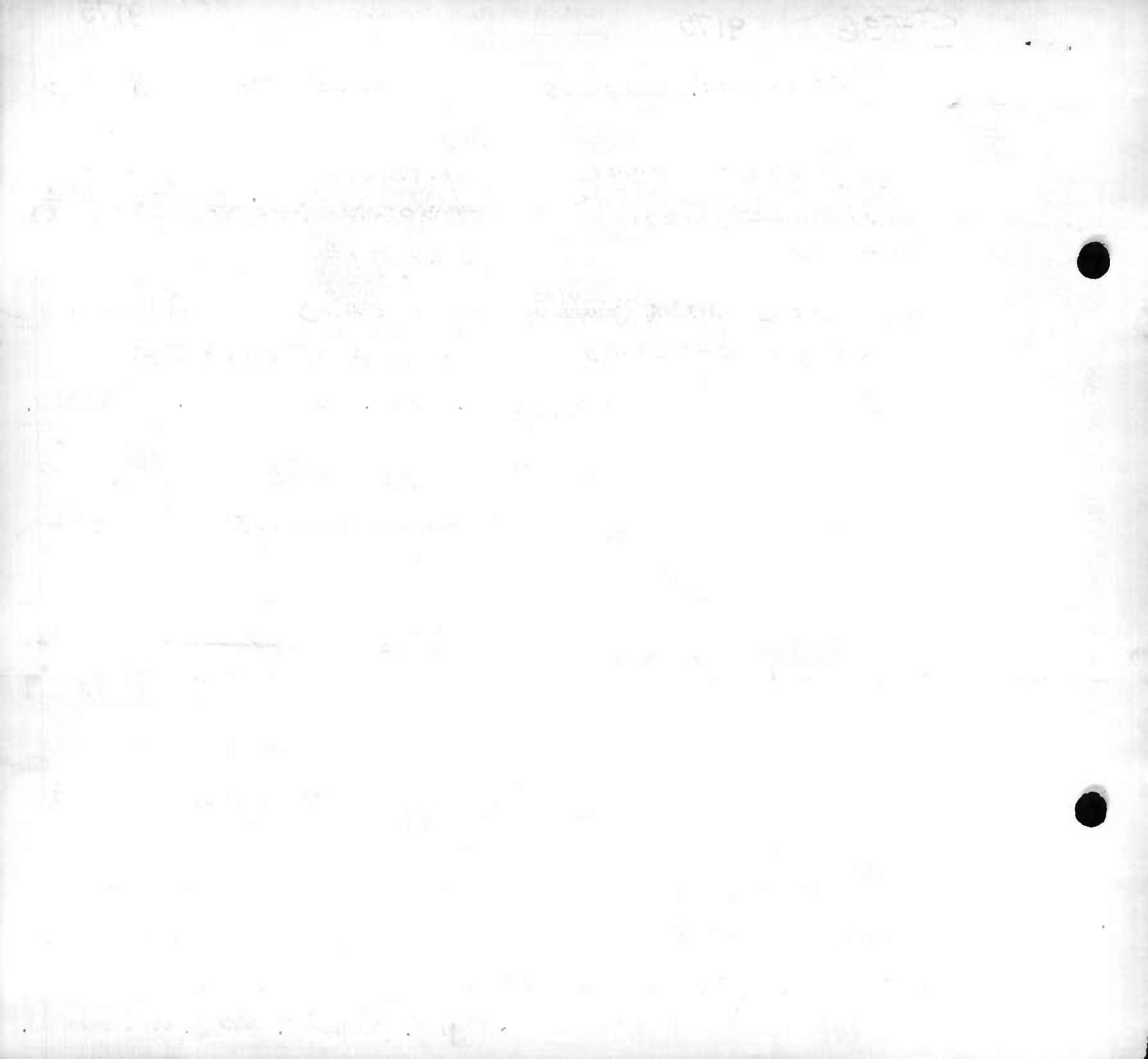
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

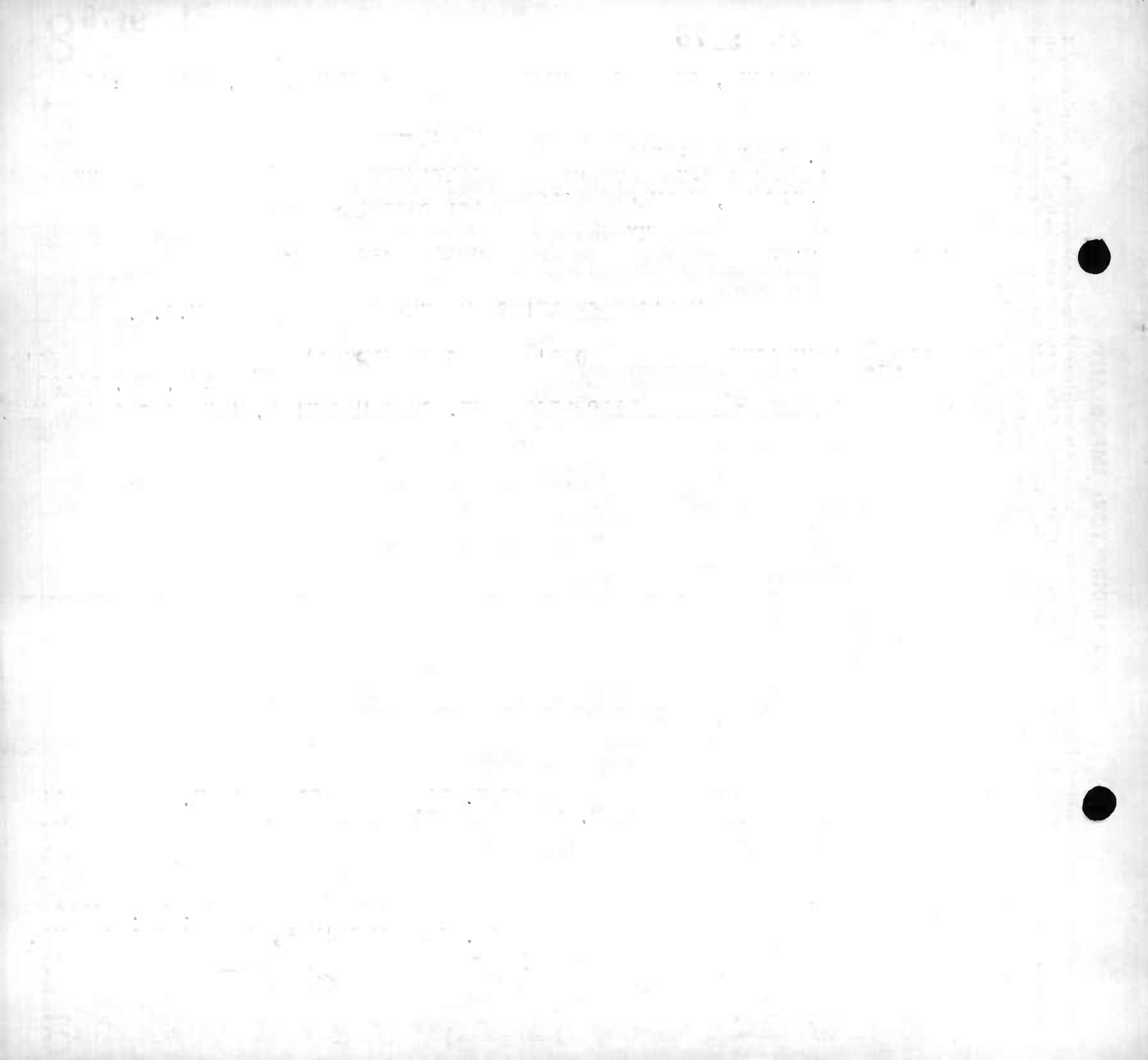
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
<div style="font-size: 2em; font-weight: bold;">S-536</div> <div style="font-size: 2em; font-weight: bold;">9175</div>		<div style="font-size: 1.5em; font-weight: bold;">9175</div>			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
JOSEPH F. SANDERS		9-28-71		15 <sup>35</sup> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
35 CHURCH Home E HOSPITAL BALTIMORE 21231		MD			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
MALE		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
RETIRED		Sexton, Our Savior Church of		12-XX-39 7	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (in years last birthday)	
JOSEPH SANDERS		ANNA STRIKEE		73	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
XXXXXX		21209 5283		Mrs. Jane S. Sanders 2934 E. Baltimore St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4369 I		Respiratory Arrest		Immediate	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Cerebrovascular Accident		18 days + longer	
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II		Pneumonia		10-14 days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		1971 to 9/28		1971	
that (I) (we) last saw the deceased alive on		9/28		19 71 and that (in my) (our) opinion death occurred on the date	
and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Samuel Morrison		9/28/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
SAMUEL MORRISON MD		11 E Chase St Balto Md 21202			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		10/1/71		Gardens of Faith Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 4 1971		John H. Moran, Inc.		3000 E. Baltimore St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

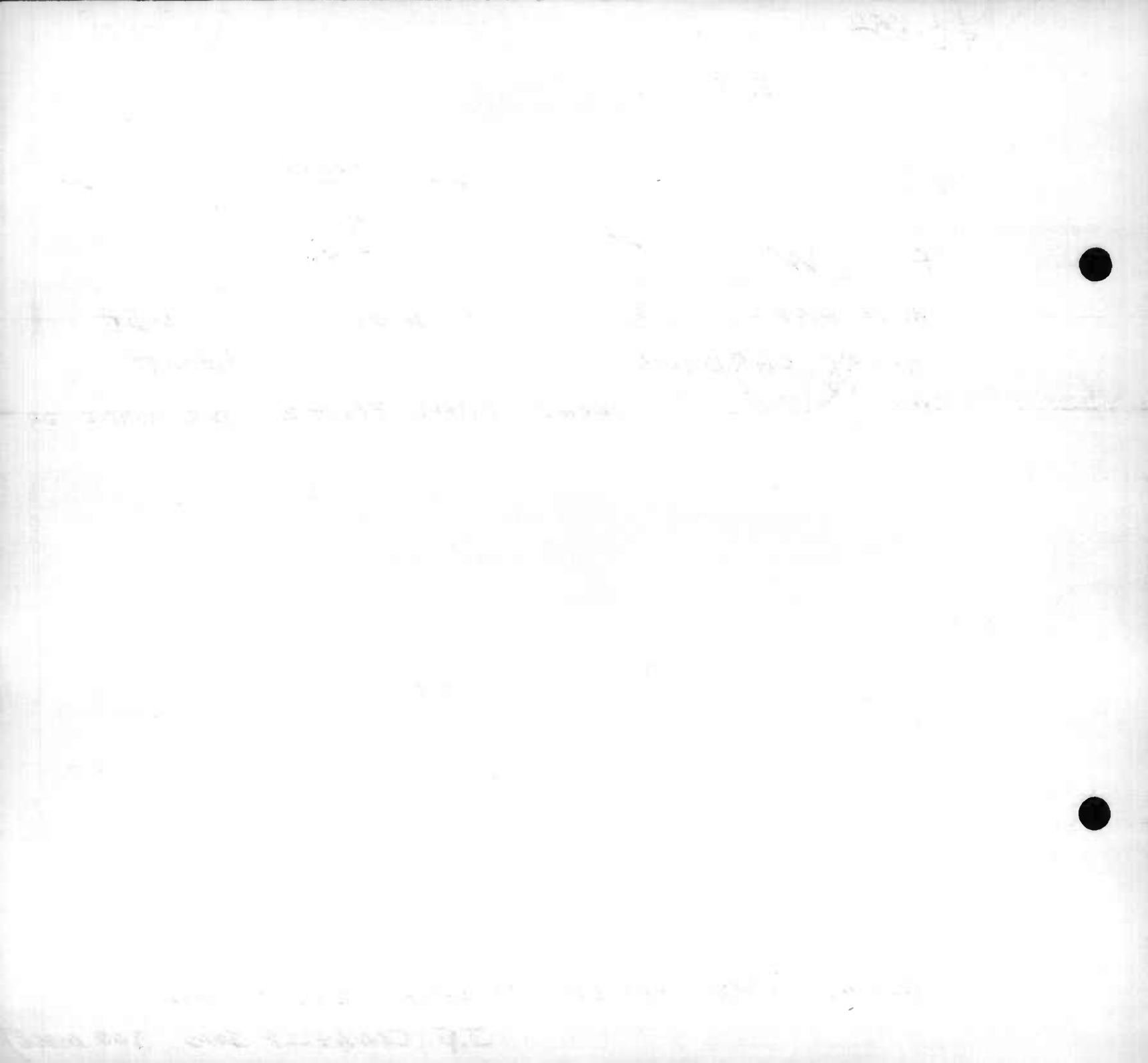
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">71 9176</span>	
D-262 71 9176		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DECHRISTE, CHARLES OLIVER		SEPTEMBER 28, 1971 4:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE, MARYLAND 21229		A. STATE MARYLAND B. COUNTY BALTO. 5300	
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 401 GREENLOW ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 1, 1909	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SAWMAN		10B. KIND OF BUSINESS OR INDUSTRY AMERICAN SMELTING		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME RICHARD DECHRISTE		14. MOTHER'S MAIDEN NAME AGNES (ZAKNS)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, give war or dates of service) YES W.W. II		16. SOCIAL SECURITY NO. 213092752		17. INFORMANT BALTO. MD. 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.4 I Bilateral pulm. emboli 2 days 5 yrs.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A S C V D. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from SEPT. 21 19 71 to SEPT. 28 19 71 that (I) (we) last saw the deceased alive on SEPT. 28 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. G. Apter, M.D.		23B. DATE SIGNED 9/28/71		23C. PHYSICIAN'S NAME (Type) J. G. Apter, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-2-71		24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cem.	
24D. LOCATION Baltimore		24E. STATE Md.		24F. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1971		25B. NAME OF REGISTRAR R. E. Taylor, R.D.		25C. FUNERAL DIRECTOR Charles J. Kavanaugh, F.H.	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. <u>71 9177</u>	
<div style="display: flex; justify-content: space-between;"> <span><u>B-652</u> <u>71</u> <u>9177</u></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>							
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <u>IRENE E. BURNS</u>				<b>2. DATE AND HOUR OF DEATH</b> <u>9-27-71</u> <u>11:00</u> <u>A.M.</u>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 SINAI HOSPITAL OF BALTIMORE</u>				<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>ESSEX</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>37 WALVERN RD.</u>			
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>6-6-18</u>	<b>9. AGE</b> (In years last birthday) <u>53</u>	<b>If Under 1 Yr.</b> Months <u>  </u> Days <u>  </u>	<b>If Under 24 Hrs.</b> Hours <u>  </u> Min. <u>  </u>	<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>
<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>			<b>11. BIRTHPLACE</b> (State or foreign country) <u>MD.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		
<b>13. FATHER'S NAME</b> <u>HARRY CARBACK</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>HEMT</u>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>CAROL POLITZ</u>			<b>ADDRESS</b> <u>166 MAPLE DR.</u>
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>174X I</u> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>  </u>				<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Adeno Carcinoma</u> <u>of the breast &amp; wide spread</u> (B) <u>bone and liver metastasis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>  </u> (C) <u>  </u>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 yrs</u>	
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <u>  </u>							
<b>19A. DATE OF OPERATION</b> <u>  </u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <u>  </u>		<b>20A. AUTOPSY?</b> (Yes or No) <u>NO</u>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <u>  </u>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <u>  </u>			
<b>21D. TIME OF INJURY</b> (Approx.) (Month) (Day) (Year) (Hour) <u>  </u>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b> <u>  </u>			
<b>22. I certify that (I) (this hospital) attended the deceased from <u>9-17</u> 19 <u>71</u> to <u>9-27</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9-27</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <u>E. T. Sutton, M.D.</u>				<b>23B. DATE SIGNED</b> <u>9-27-71</u>		<b>23C. PHYSICIAN'S NAME</b> (Type) <u>ELLA T. SUTTON, M.D.</u>	
<b>23D. ADDRESS</b> <u>SINAI HOSPITAL</u>				<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>			
<b>24B. DATE</b> <u>9/30/71</u>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>GARDENS OF FAITH</u>		<b>24D. LOCATION</b> (City, town, or county) (State) <u>BALTO. MD.</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>OCT 4 1971</u>	
<b>25B. NAME OF REGISTRAR</b> <u>Robt E. J. ...</u>		<b>25C. FUNERAL DIRECTOR</b> <u>J. J. CONNELLY SONS</u>		<b>ADDRESS</b> <u>300 MA...</u>			

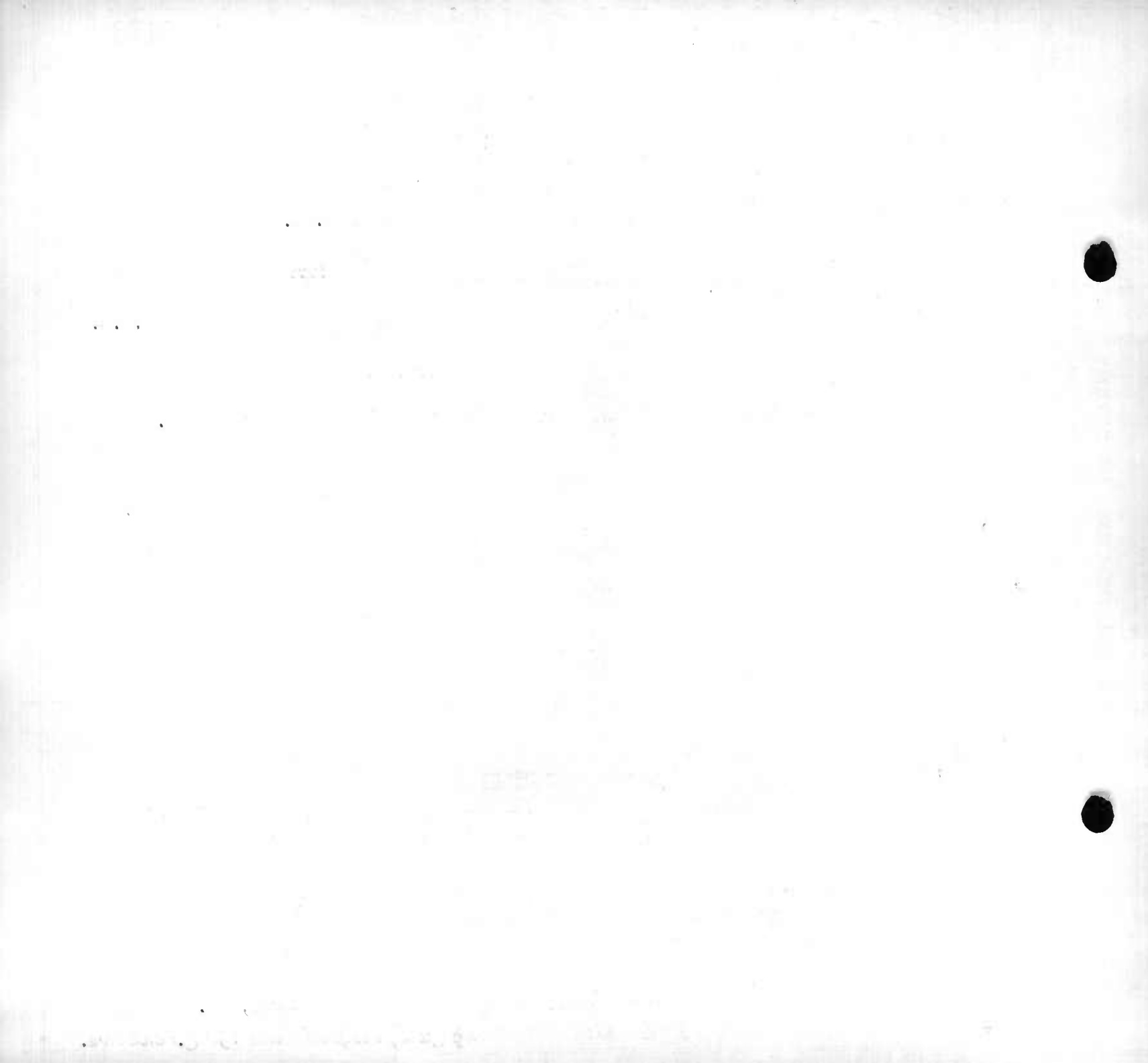




# FUNERAL DIRECTOR: IMPORTANT

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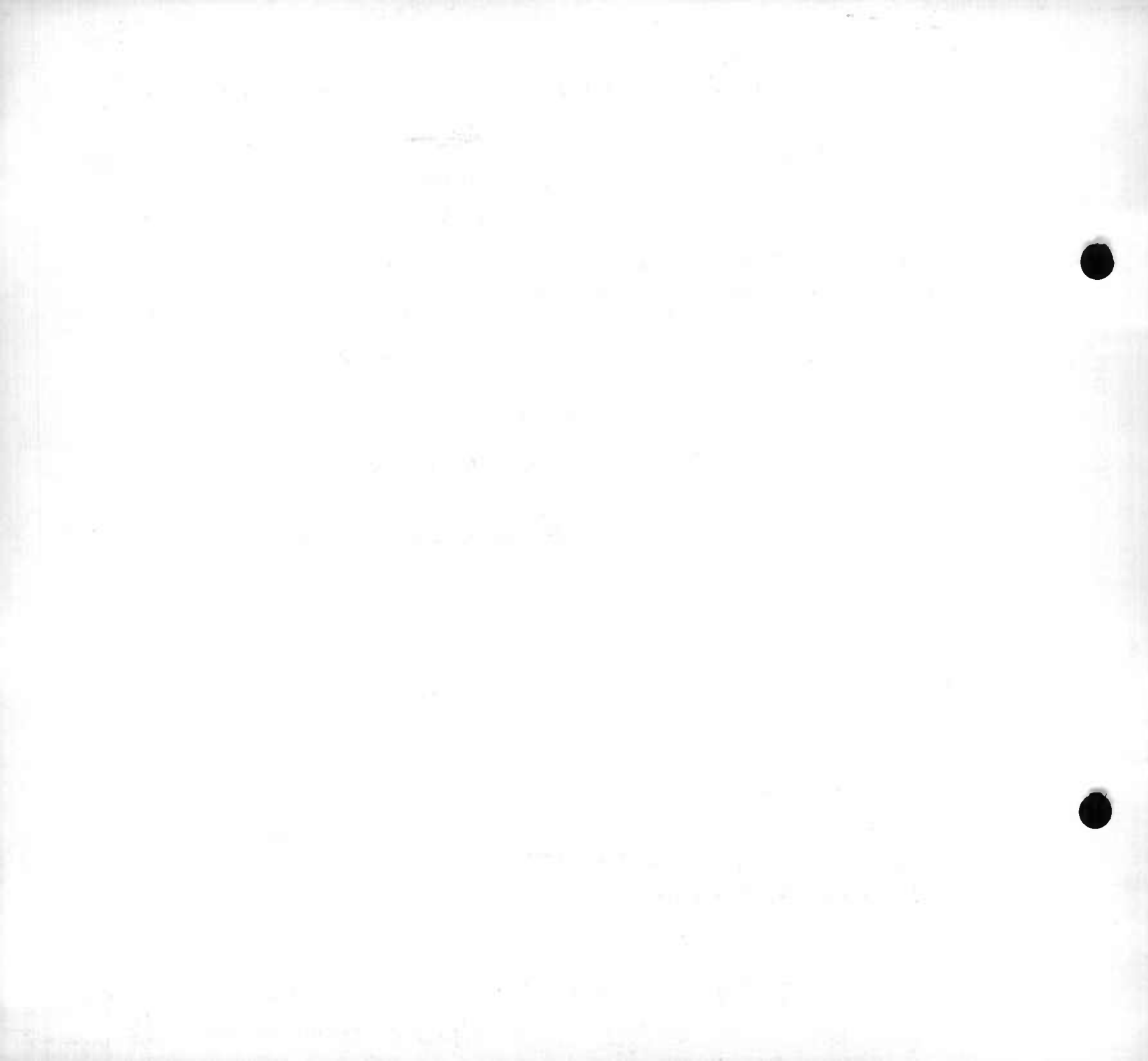
<h2 style="margin: 0;">Baltimore City Health Department</h2> <h3 style="margin: 0;">CERTIFICATE OF DEATH</h3>		REG. NO. <span style="font-size: 1.5em;">71 9178</span>
BIRTH NO. <span style="font-size: 1.5em;">S-350 71 9178</span>		DATE AND HOUR OF DEATH <span style="font-size: 1.5em;">10-01-71 18 AM</span>
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.5em;">BENJAMIN STEIN</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.5em;">10-01-71 18 AM</span>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">Church Home and Hospital 100 N. Broadway St. Baltimore MD. 21231</span>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <span style="font-size: 1.5em;">MD</span> B. COUNTY <span style="font-size: 1.5em;">BALTIMORE</span> C. CITY OR TOWN <span style="font-size: 1.5em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.5em;">1302 Wilson Pt. Rd.</span>
5. SEX <span style="font-size: 1.5em;">Male</span> 6. RACE <span style="font-size: 1.5em;">White</span> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.5em;">09-26-905</span> 9. AGE (In years last birthday) <span style="font-size: 1.5em;">65 66</span>	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">Germany</span> 12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.5em;">U.S.A.</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">Truck Driver</span> 10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.5em;">Trucking</span>		13. FATHER'S NAME <span style="font-size: 1.5em;">Henry Stein</span> 14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">Unknown</span>
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">no</span>	16. SOCIAL SECURITY NO. <span style="font-size: 1.5em;">unknown</span>	17. INFORMANT <span style="font-size: 1.5em;">Joseph Stein 4946 Brookwood Rd.</span> ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Thrombosis of Right middle Cerebral Artery</span> (B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Arteriosclerosis</span> (C) <span style="font-size: 1.5em;">Coronary insufficiency</span> <span style="font-size: 1.5em;">Arteriosclerotic Cardiovascular Disease</span>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">24 Days</span> <span style="font-size: 1.5em;">many years</span>
19A. DATE OF OPERATION <span style="font-size: 1.5em;">none</span> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.5em;">none</span>	20A. AUTOPSY? (Yes or No) <span style="font-size: 1.5em;">none</span> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <span style="font-size: 1.5em;">none</span>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.5em;">none</span>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <span style="font-size: 1.5em;">none</span>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <span style="font-size: 1.5em;">none</span>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <span style="font-size: 1.5em;">none</span>
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">9-7-71</span> to <span style="font-size: 1.5em;">10-01-71</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">10/1</span> 19 <span style="font-size: 1.5em;">71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <span style="font-size: 1.5em;">Dr. Sayadi</span>		23B. DATE SIGNED <span style="font-size: 1.5em;">10-01-71</span>
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">Dr. Sayadi</span>	23D. ADDRESS <span style="font-size: 1.5em;">CH &amp; H</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">Burial</span>	24B. DATE <span style="font-size: 1.5em;">10/4/71</span>	24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.5em;">Cedar Hill Cemetery</span>
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.5em;">Baltimore, Md.</span>		
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">OCT 4 1971</span>	25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">R. E. F. 120</span>	25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">McCall's Funeral Home 130 E. Fort Ave.</span> ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 9179	
CERTIFICATE OF DEATH				REG. NO. 71 9179	
BIRTH NO. <u>7-655</u>		71 9179			
1. NAME OF DECEASED (Type or Print) <u>VERNON FOREMAN</u>		2. DATE AND HOUR OF DEATH <u>10/2/71</u> <u>11:08</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MUNTEBELLO STATE HOSP.</u>		A. STATE <u>MARYLAND</u>		B. COUNTY <u>2301</u>	
C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>1324 S. CHARLES ST.</u>					
5. SEX <u>M</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/4/01</u>	9. AGE (In years last birthday) <u>70</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>218-10-4883</u>		17. INFORMANT <u>CLINICAL RECORD</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>201X I</u>		CAUSE OF DEATH <u>PNEUMONITIS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>NOOBIKIN'S DISEASE</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>1969</u>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>DEHYDRATION</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>Richard H. Mack, M.D.</u> attended the deceased from <u>6 JULY</u> 19 <u>71</u> to <u>2 OCT</u> 19 <u>71</u> that <u>he</u> last saw the deceased alive on <u>2 OCT</u> 19 <u>71</u> and that in <u>my</u> opinion death occurred on the date and hour and from the causes stated above. <u>(I) (We) (did) (didn't)</u> view the body after death.					
23A. SIGNATURE <u>Richard H. Mack, M.D.</u>		23B. DATE SIGNED <u>2 OCT. 1971</u>			
23C. PHYSICIAN'S NAME (Type) <u>RICHARD H. MACK, M.D.</u>		23D. ADDRESS <u>MUNTEBELLO STATE HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/5/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Cedar Hill Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>John J. Lazarus Inc.</u>	
25D. ADDRESS <u>29 Hollinsworth St.</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						CERTIFICATE OF DEATH		REG. NO. <b>71 9180</b>	
BIRTH NO. <b>M-622 71 9180</b>		1. NAME OF DECEASED (Type or Print) <b>Markiewicz, Jame Michael</b>				2. DATE AND HOUR OF DEATH <b>Sept. 26, 1971 10:15 a.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>43 South Baltimore General Hospital</b> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2605</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 22, 1901</b>		9. AGE (In years last birthday) <b>69</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector - Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>American Standard Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>John</b>				14. MOTHER'S MAIDEN NAME <b>Josephine ?</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>213-01-4377</b>		17. INFORMANT <b>Anna Markiewicz (wife) same address</b>					
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia with electrolyte imbalance</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) DUE TO, OR AS A CONSEQUENCE OF:									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <del>(N)</del> (this hospital) attended the deceased from <b>Sept. 23</b> 19 <b>71</b> to <b>Sept. 26</b> 19 <b>71</b> that <del>(N)</del> (we) last saw the deceased alive on <b>Sept. 26</b> 19 <b>71</b> and that <del>(N)</del> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>(N)</del> (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Chiu Sung Chan, M.D.</b> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Sept. 26, 1971</b>			
23C. PHYSICIAN'S NAME (Type) <b>Chiu Sung Chan, M.D.</b> DEGREE				23D. ADDRESS <b>South Baltimore General Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/30/71</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Stanislaus Cemetery</b>		24D. LOCATION (City, town, or county) <b>Balto. Md.</b>		(State)	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.O.</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Homes, Inc.</b>		ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>			

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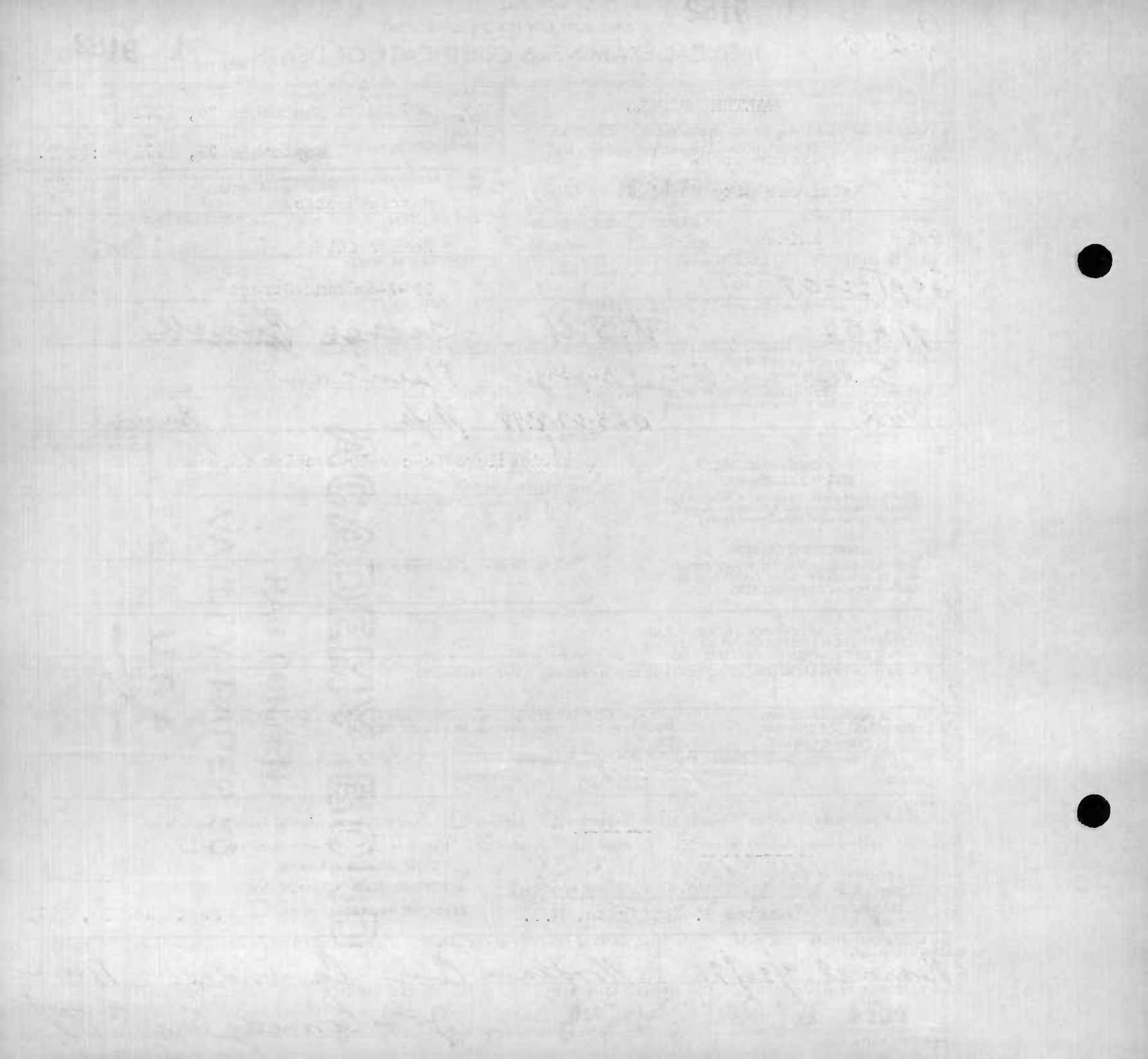
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>711 91810</u>
BIRTH NO. <u>H-426</u>		71 9181		
1. NAME OF DECEASED (Type or Print) <u>Hilker William III</u>		2. DATE AND HOUR OF DEATH <u>9/27/71</u> <u>5<sup>10</sup></u> <u>AM.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2632</u>		
5. SEX <u>M</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Antique Shop</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>self-employed</u>		8. DATE OF BIRTH <u>10-31-27</u>
13. FATHER'S NAME <u>Wm. Hilker</u>		14. MOTHER'S MAIDEN NAME <u>Anna -</u>		9. AGE (In years last birthday) <u>43</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>220-22-6880</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>
17. INFORMANT <u>Helen Hilker (wife) same address</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Resp./Cardiac arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Bilateral Unilateral Obstruction</u> <u>Metastatic Carcinoma of Colon</u> <u>Intestinal Obst. 2nd day to Carcinoma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>		
MEDICAL CERTIFICATION				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Intestinal Obst. 2nd day to Carcinoma</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>9/20</u> 19 <u>71</u> to <u>9/27</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>9/26</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>David Bowman, MD</u>		23B. DATE SIGNED <u>9/27/71</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>DAVID BOWMAN</u>		23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/30/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc.</u>		
25D. ADDRESS <u>3331 Brehms Lane, Balto. Md. 21213</u>				





BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		WALTER RUSSELL		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year September 29, 1971	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Baltimore City Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year September 29, 1971		Hour 6:45 P.	
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Massachusetts	
9. DATE OF BIRTH Sept 22-07		10. AGE (In years last birthday) 64		11. BIRTHPLACE (State or foreign country) MASS.		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME George Russell		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Central Supply Co.		15. MOTHER'S MAIDEN NAME Buncan		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) CNK	
17. SOCIAL SECURITY NO. 023-07-3348		18. INFORMANT Wife		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, public bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED September 30, 1971	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 9/30/71		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cem		24D. LOCATION (City, town, or county) (State) Cambridge Mass.	
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR J. G. Connelly Sons		ADDRESS Essex Ind.	



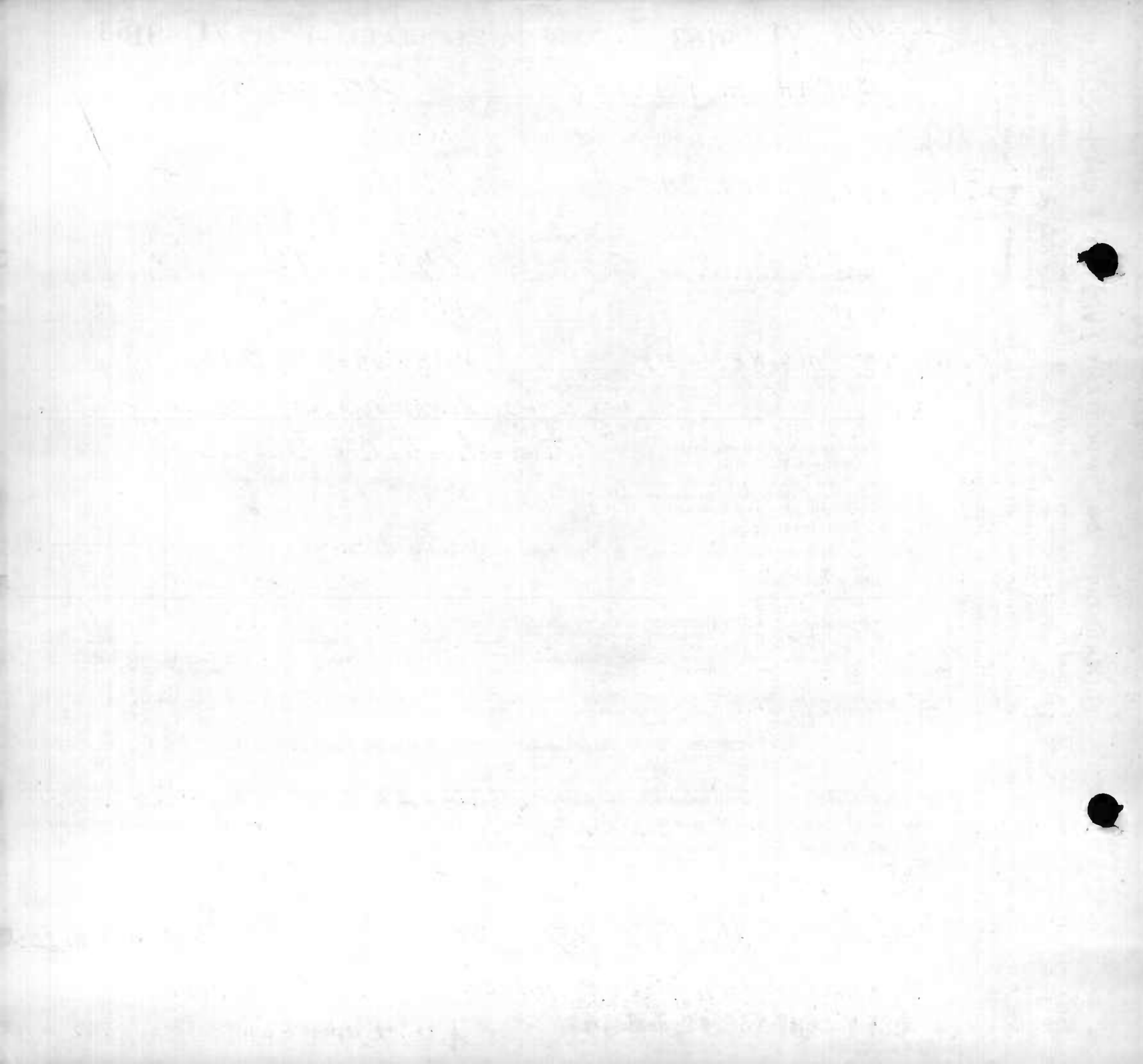
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **71 9183**

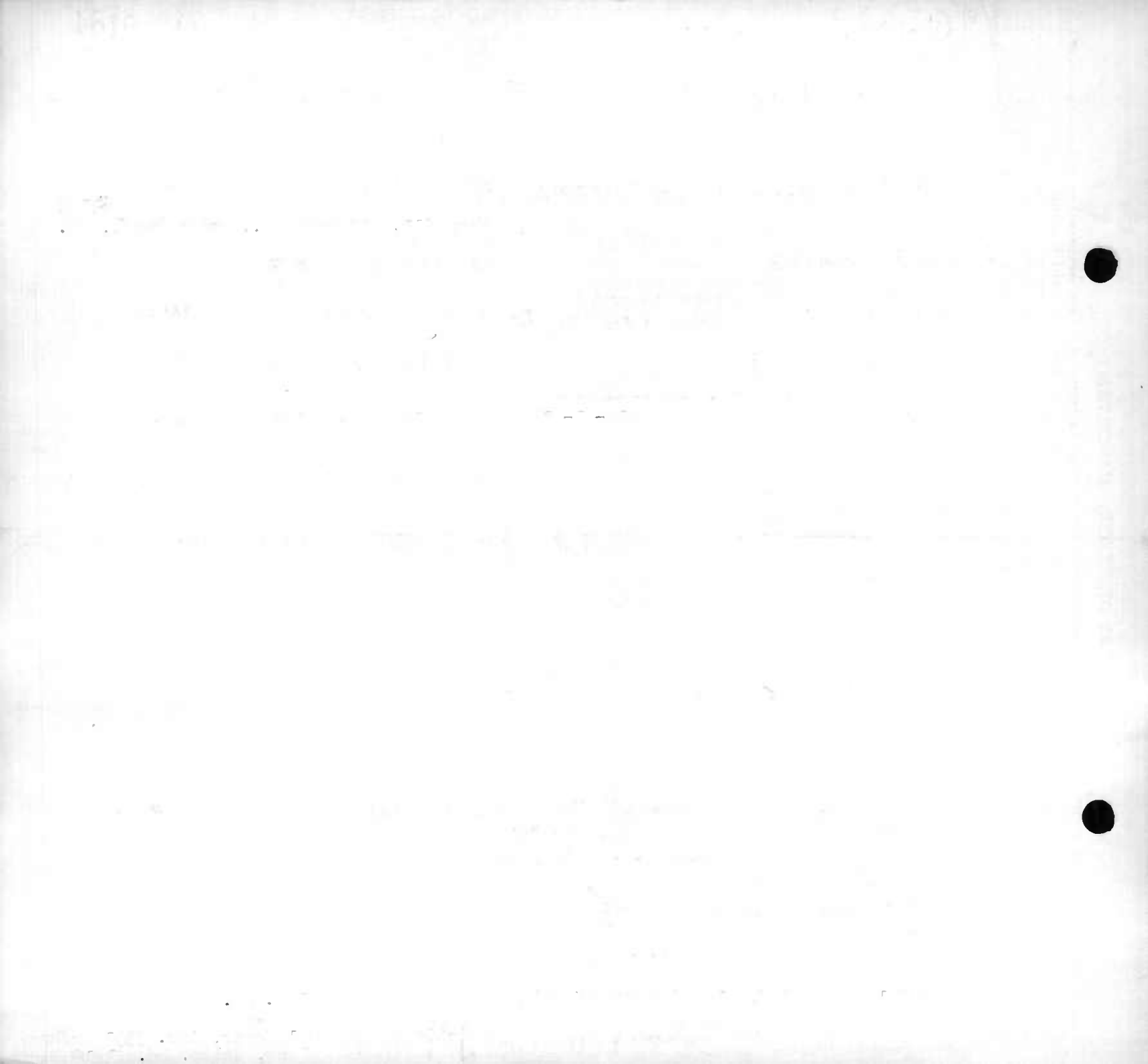
<p><b>7-640 71 9183</b></p> <p>BIRTH NO.</p>		<p>1. NAME OF DECEASED (Type or Print) <b>SARAH A. FARLEY</b></p>		<p>2. DATE AND HOUR OF DEATH <b>SEPT. 28, 1971</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTO. CITY HOSP.</b></p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2636</b></p> <p>C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>6313 ELLIOTT ST.</b></p>		
<p>5. SEX <b>F</b> 6. RACE <b>W</b></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <b>8/7/93</b> 9. AGE (In years last birthday) <b>78</b></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <b>W. VA.</b></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>			<p>13. FATHER'S NAME <b>ALLEN MCKENNEY</b></p>		
<p>14. MOTHER'S MAIDEN NAME <b>MARGARET BASHAM</b></p>			<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b></p>		
<p>16. SOCIAL SECURITY NO. <b>236-32-4673</b></p>		<p>17. INFORMANT ADDRESS <b>HENRY FARLEY 5820 COMSTOCK</b></p>			
<p><b>II</b></p> <p>CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Arteriosclerotic CV. Disease</i></p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>18. <b>412.4</b></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>			
<p>19A. DATE OF OPERATION <b>0</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>			
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>July 27, 1971</b> to <b>Sept 28, 1971</b>, that (I) (we) last saw the deceased alive on <b>July 25, 1971</b> and that in (my) (<del>our</del>) opinion death occurred on the date and hour and from the causes stated above. (I) (<del>we</del>) (<del>did</del>) (<del>not</del>) view the body after death.</p>					
<p>23A. SIGNATURE <b>Henry J. Houska M.D.</b> DEGREE</p>				<p>23B. DATE SIGNED</p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>HENRY J. HOUSKA M.D.</b> DEGREE</p>				<p>23D. ADDRESS <b>333 S. EAST AVE BALTO MD 21224</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b></p>		<p>24B. DATE <b>10/2/71</b></p>		<p>24C. NAME OF CEMETERY or CREMATORY <b>GLEN HAVEN</b></p>	
<p>24D. LOCATION (City, town, or county) <b>BALTO. MD.</b></p>		<p>24E. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1971</b></p>			
<p>25A. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b></p>		<p>25B. NAME OF REGISTRAR</p>		<p>25C. FUNERAL DIRECTOR ADDRESS <b>J. F. CONNELLY SONS 300 MACE</b></p>	



# FUNERAL DIRECTOR: IMPORTANT

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C-100 71 9184		BALTIMORE CITY HEALTH DEPARTMENT		71 9184	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>COVEY, NEWTON F.</b>			2. DATE AND HOUR OF DEATH <b>Sept 29, 1971 10:15 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME &amp; HOSPITAL 35</b>			A. STATE <b>MARYLAND BALTO</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY <b>5300</b>		
5. SEX <b>MALE</b>			6. RACE <b>WHITE</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>12/31/13</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MANAGER</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>IRON &amp; METAL CO.</b>		
13. FATHER'S NAME <b>FLOYD COVEY</b>			14. MOTHER'S MAIDEN NAME <b>MINNIE BAMBERT</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>214-01-2133</b>		
17. INFORMANT <b>Beverly Covey (wife) same address</b>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>162.1 I</b> [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <b>RESPIRATORY INSUFFICIENCY (month)</b> DUE TO, OR AS A CONSEQUENCE OF:		
			(B) <b>CANCER OF LEFT LUNG &amp; METASTASIS 6 MONTH</b> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>19/3/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CERVICAL NODE BIOPSY</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(I)</del> (this hospital) attended the deceased from <b>Sept 1 1971</b> 19 to <b>Sept 28 1971</b> 19 that (I) <del>(we)</del> last saw the deceased alive on <b>Sept 28 1971</b> 19 and that (in my) <del>(last)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) (did not) view the body after death.					
23A. SIGNATURE <b>T. Sree Ramamurthy</b>				23B. DATE SIGNED <b>9/29/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>T. SREE RAMAMURTHY</b>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>10/2/71</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Homes, Inc. 3331 Brehms</b>	
				ADDRESS <b>Lena, Balto. Md. 21223</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		REG. NO. <u>71 9185</u>	
BIRTH NO. <u>K-613 71 9185</u>		2. DATE AND HOUR OF DEATH <u>9-29-71</u> <u>2:30</u> P. M.	
1. NAME OF DECEASED (Type or Print) <u>ELSIE D. KRAFT</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2643</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Church Home and Hospital</u> <u>100 N Broadway St Balti 21231</u>		C. CITY OR TOWN <u>Baltimore City</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2527 EMLEY AVE 21213</u>	
5. SEX <u>Female</u> 6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>02-06-06</u> 9. AGE (In years last birthday) <u>65</u>	11. BIRTHPLACE (State or foreign country) <u>MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>American</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
13. FATHER'S NAME <u>Charles Steinert</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Brown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-22-6260</u>	
17. INFORMANT <u>A. Fouad Nouz M.D. Church Home Hospital</u>		ADDRESS <u>Church Home Hospital</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>153.8 &amp; 250.9</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>DIABETES MELLITUS</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cancer Colon -</u> <u>inoperable and metastasizing to the liver.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Liver failure due to</u> <u>metastasis from Cancer</u> (C) <u>COLON</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u> <u>24 YRS.</u>	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>NONE</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NONE</u> 20A. AUTOPSY? (Yes or No) <u>NONE</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NONE</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NONE</u> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NONE</u> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NONE</u> 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>NONE</u> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? <u>NONE</u>	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>9.14.1971</u> to <u>9.29.1971</u> that (I) <u>(we)</u> last saw the deceased alive on <u>9.29.1971</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death.			
23A. SIGNATURE <u>Rustum. Irani</u> M.D. 23C. PHYSICIAN'S NAME (Type) <u>RUSTUM IRANI</u> M.D.		23B. DATE SIGNED <u>9.29.1971</u> 23D. ADDRESS <u>CHURCH HOME AND HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10/4/71</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1971</u>		25B. NAME OF REGISTRAR <u>John E. Taylor, Jr.</u>	
25C. FUNERAL DIRECTOR <u>Schumanek Funeral Homes, Inc.</u>		ADDRESS <u>3331 Brehms Lane, Balto. Md. 21213</u>	



3527 Emily Ave

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="font-size: 2em; font-weight: bold;">B-650 71 9186</div>		<div style="font-weight: bold;">BALTIMORE CITY HEALTH DEPARTMENT</div>		<div style="font-weight: bold;">CERTIFICATE OF DEATH</div>		<div style="font-weight: bold;">REG. NO. 71 9186</div>	
1. NAME OF DECEASED (Type or Print) <b>BROWN, EVELYN CAMILLA</b>				2. DATE AND HOUR OF DEATH <b>9/27/71 1045 a.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Union Memorial Hospital, 4433 Calvert Sts. 21218</b>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Balto. city 2834</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4818 Lindsay Rd., MD 21229</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-16-07</b>	9. AGE (In years last birthday) <b>64</b>	10. Under 1 Yr. Months	11. Under 24 Hrs. Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Buyer-Dry Goods</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Buyer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A. America</b>	
13. FATHER'S NAME <b>Fredrick W. Brown</b>				14. MOTHER'S MAIDEN NAME <b>Camilla B. Thiele</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] <b>unknown - - - -</b>		16. SOCIAL SECURITY NO. <b>212 09 9225</b>		17. INFORMANT ADDRESS <b>Mrs. Thelma Zavec 4818 Lindsay Rd 21229</b>			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>151.9 I</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Left hemiparesis, secondaries.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Bronchopneumonia</b> (B) <b>carcinoma stomach</b> DUE TO, OR AS A CONSEQUENCE OF: (C)			
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>None</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>No</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>None</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>No</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>9-13-1971</b> to <b>9-27-1971</b> that (I) (we) lost saw the deceased alive on <b>9-27-1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>S. Desai</b>				M.D. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9-27-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>S. DESAI</b>		M.D. DEGREE		23D. ADDRESS <b>Union Memorial Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Sep. 30, 1971</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>J. E. Lowell</b>		ADDRESS <b>Lemmon 6500 York Road</b>	

22/1/41  
1/1/41

1/1/41

1/1/41



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT																			
P-300 71 9187					CERTIFICATE OF DEATH					REG. NO. 71 9187									
1. NAME OF DECEASED (Type or Print) <u>Piet Sr, Harry R.</u>					2. DATE AND HOUR OF DEATH <u>10/1/71 5:45 AM</u>														
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u> <u>33</u>					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Balt Md</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>101 N Rolling Rd</u>														
5. SEX <u>M</u>		6. RACE <u>Cau.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/1/06</u>		9. AGE (In years last birthday) <u>65</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Investment Banker</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>John D. Howard &amp; Co</u>														
13. FATHER'S NAME <u>Harry R. Piet, Sr.</u>					14. MOTHER'S MAIDEN NAME <u>Laura Hoff</u>														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>					16. SOCIAL SECURITY NO. <u>212-03-5463</u>		17. INFORMANT <u>Mr. H. Richard Piet, 1208 John Street</u>					ADDRESS							
18. <u>185X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiorespiratory Arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Prostatic CA, metastatic</u>										CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
										(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:									
										(B) DUE TO, OR AS A CONSEQUENCE OF:									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).																			
19A. DATE OF OPERATION <u>10/1</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <u>No</u>									
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that <u>we</u> (this hospital) attended the deceased from <u>9/10</u> 19 <u>71</u> to <u>10/1</u> 19 <u>71</u> that <u>we</u> last saw the deceased alive on <u>10/1</u> 19 <u>71</u> and that <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>we</u> (We) (did) <u>not</u> view the body after death.																			
23A. SIGNATURE <u>L E Rambler MD</u>					23B. DATE SIGNED <u>10/1/71</u>														
23C. PHYSICIAN'S NAME (Type) <u>Louis E. Rambler MD</u>					23D. ADDRESS <u>Johns Hopkins Hosp.</u>														
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>10/4/71</u>					24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>									
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>																			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1971</u>					25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD</u>					25C. FUNERAL DIRECTOR <u>Nitzke</u> ADDRESS <u>1630 Edmondson Ave., 21228</u>									

August 18

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">71 9188</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.2em;">H-620</span>		<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Harris, Odell</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">October 2, 1971 8:05 P.M.</span>	
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">38 University Hospital</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <span style="font-size: 1.2em;">Maryland</span> <b>B. COUNTY</b> <span style="font-size: 1.2em;">2101</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">331 S. Fremont Ave</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">Negro</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">1/9/13</span>	<b>9. AGE</b> in years (last birthday) <span style="font-size: 1.2em;">58</span>	<b>If Under 1 Yr.</b> Months: <span style="font-size: 1.2em;"> </span> Days: <span style="font-size: 1.2em;"> </span> Hours: <span style="font-size: 1.2em;"> </span> Min.: <span style="font-size: 1.2em;"> </span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">USA</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Everett Sneed</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Lucy</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Chester Harris</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">331 S. Fremont Ave</span>	
<b>18. 576-01</b> <b>CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE</b> <span style="font-size: 1.2em;">Obstructive Jaundice</span> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B)</b> <span style="font-size: 1.2em;">(month)</span> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C)</b>					
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY</b> (Yes or No) <span style="font-size: 1.2em;">No</span>	
<b>21A. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">Sept 17, 1971</span> <b>to</b> <span style="font-size: 1.2em;">Oct 2, 1971</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">Oct 2, 1971</span> <b>and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Lawrence Mills</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">Oct 2, 1971</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">LAWRENCE MILLS</span>				<b>23D. ADDRESS</b>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)		<b>24B. DATE</b>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Washington</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">North Carolina</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">OCT 4 1971</span> <b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. ...</span> <b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Charles H. Rice</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">661 W. Lane St</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>R-240 71 9189</b>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>71 9189</b>	
1. NAME OF DECEASED (Type or Print) <b>Robert Rozzell</b>			2. DATE AND HOUR OF DEATH <b>Sep-29-71 8:00 AM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>South Baltimore Gen Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>230-2</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore Gen Hospital</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>M.</b> 6. RACE <b>C</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>5-3-00</b>		9. AGE (in years last birthday) <b>71</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>BRO Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>N. C.</b>
13. FATHER'S NAME <b>Frank Rozzell</b>			14. MOTHER'S MAIDEN NAME <b>Susan Madowell</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>PT's Chant</b>
18. <b>412-4 I</b>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Bilateral</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>Cerebrovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic Cardiovascular disease</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sep 16 1971</b> to <b>Sep 29 1971</b> that (I) (we) last saw the deceased alive on <b>Sep 29 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>9/29/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Yung S. Pang</b>				23D. ADDRESS <b>South Baltimore Gen Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-4-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Westport Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Charles G. Rice</b>	
				ADDRESS <b>661 W. Banne St.</b>	

Western  
Railroad

Charles F. Smith, Secy. & Treas.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

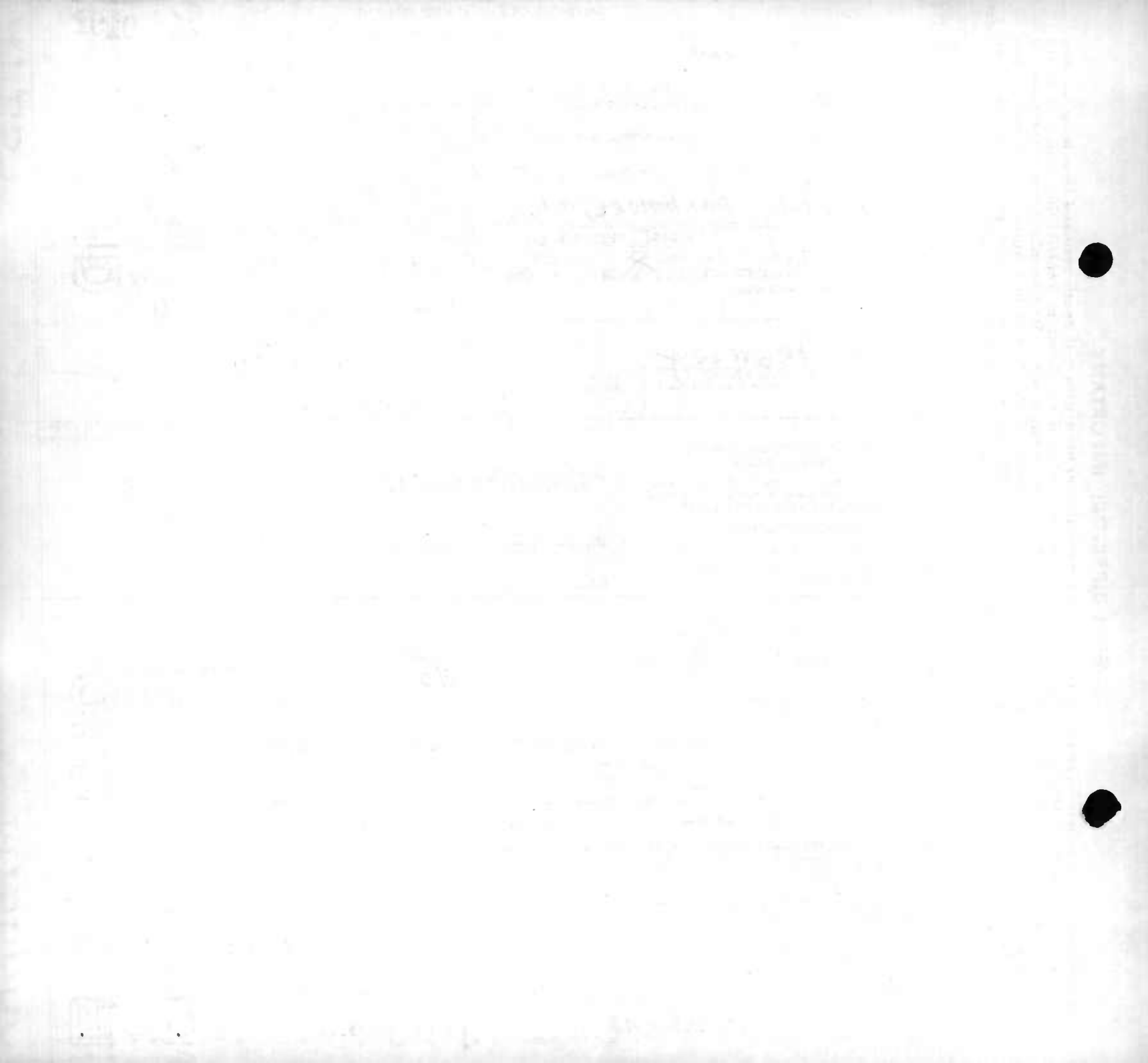
BALTIMORE CITY HEALTH DEPARTMENT				71 9180	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>Battle, Ludlow</b>				2. DATE AND HOUR OF DEATH <b>9/28/71 11:45 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>4613 - Park Heights Ave</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MT. SIMIA NURSING HOME</b> <b>4613 PARK HEIGHT AVE BALTO 21215</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
5. SEX <b>M</b> 6. RACE <b>N</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>2-10-96</b> 9. AGE (in years last birthday) <b>75</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - unempl.</b>				11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
13. FATHER'S NAME <b>Boston Battle</b>				14. MOTHER'S MAIDEN NAME <b>Viola Warring</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-09-2499</b>	
17. INFORMANT <b>Louise Harris</b>				ADDRESS <b>2538 Oswego Ave BALTO MD 21215 (MOY. 6643)</b>	
18. <b>403X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Ute ureia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Nephrosclerosis</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Ute renal structure</b>				<b>Years</b>	
19A. DATE OF OPERATION <b>9/15</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/15</b> to <b>9/28</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>9/15</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date <b>9/28</b> 19 <b>71</b> and haul and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>10/1/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>V. A. S. H.</b>				23D. ADDRESS <b>206, S. Lincoln, Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10.2.71</b>		24C. NAME of CEMETERY or CREMATORY <b>MT. AUBURN</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1971</b>			
25A. NAME OF REGISTRAR <b>Charles A. Rice</b>		25B. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>661 W. Barre St.</b>	

Donald had been in a  
number of institutions  
before he was admitted  
to Mt Sinai. AT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

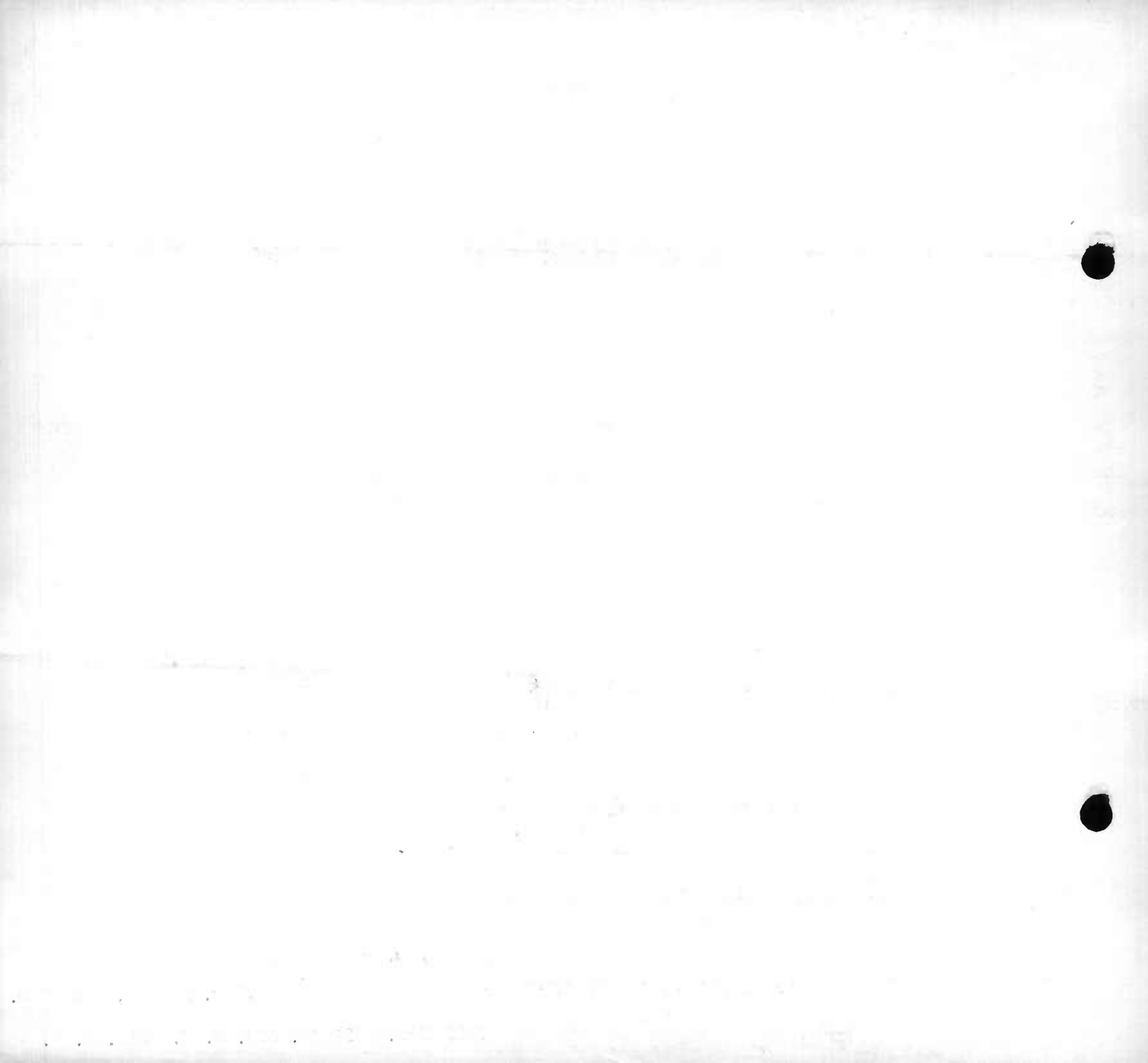
Baltimore City Health Department				REG. NO. 71 9191	
7-300 71 9191		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Fayette Catherine</i>		2. DATE AND HOUR OF DEATH <i>9-30-71 2pm M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i>		A. STATE <i>md.</i> B. COUNTY <i>Prince George Co.</i>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>3100 S. Hanover St Baltimore, md 21230</i>		C. CITY OR TOWN <i>Laureh</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>10-24-95</i>	
13. FATHER'S NAME <i>James Frarvey</i>		14. MOTHER'S MAIDEN NAME <i>Julia Naughton</i>		9. AGE (in years lost birthday) <i>75</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>138-20-5638</i>		17. INFORMANT <i>Hospital Records</i>	
18. <i>199.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Uremia</i>		(B) <i>Metastatic Sarcoma</i> DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____		11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9/30</i> <i>71</i> to <i>9/30</i> <i>71</i> that (I) (we) last saw the deceased alive on <i>9/30</i> <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Castillo</i>		23B. DATE SIGNED <i>9/30/71</i>		23C. PHYSICIAN'S NAME (Type) <i>M.D. DEGREE</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/4/71</i>		24C. NAME of CEMETERY or CREMATORY <i>Gate of Heaven Cemetery</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 4 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. J. ...</i>		25C. FUNERAL DIRECTOR <i>Ac Gully Funeral Home</i>	
24D. LOCATION <i>East Hanover New Jersey</i>		25D. ADDRESS <i>130 E. Fort Ave.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. <u>71 9192</u>	
W-51271 9192				CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		WIMBUSH GWENDOLYN		Sept 26 <sup>th</sup> 1971		3:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
GOOD SAMARITAN HOSP 45				WASHINGTON D.C. V 48			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				WASHINGTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				174 DARRINGTON ST.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
F	N	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12-10-40		30 yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		None				U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
IRA JOHNSON				DOROTHY Strong			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		577-54-7580					
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				9.1 Bleeding			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				Systemic Sclerosis			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Renal failure of systemic sclerosis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0 None							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
None							
21D. TIME OF INJURY (APPROX)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 1<sup>st</sup></u> 19 <u>71</u> to <u>Sept 26<sup>th</sup></u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Sept 25<sup>th</sup></u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
John C. Wheelton MB.MRCP DEGREE				Sept 26 <sup>th</sup> 1971			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
JOHN C. WHEELTON MB.MRCP DEGREE		GOOD SAMARITAN HOSP. BALTIMORE MD.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		9/30/1971		CARVER MEMORIAL CEMETERY		WASHINGTON BLVD. LAUREL, MARYLAND.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 4 1971		000		LADNEY'S 3831		GA. AVE. N. W. EASH, D. C.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 9193		REG. NO. 71 9193	
BIRTH NO. 71 9193				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Mr. John T. Joyner</u>				2. DATE AND HOUR OF DEATH <u>9/29/71</u> <u>10<sup>15</sup> P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> <u>34</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Maryland</u>		B. COUNTY <u>1901</u>	
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1425 W. Fayette St.</u>			
5. SEX <u>Male</u>	6. RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-28-02</u>	9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Manths	If Under 24 Hrs. Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Joyner</u>				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>240-14-1820</u>		17. INFORMANT ADDRESS			
18. <u>593.2 I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Asotemia</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <u>Renal Insufficiency</u>			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>none</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/25/71</u> 1971 to <u>9/29</u> 1971 that (I) (we) last saw the deceased alive on <u>9/29</u> 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Somchai Werasophon M.D.</u>				23B. DATE SIGNED <u>9/29/71</u>		23C. PHYSICIAN'S NAME (Type) <u>SOMCHAI WERASOPHON</u>	
23D. ADDRESS <u>BON SECOURS HOSPITAL</u>				23E. FUNERAL DIRECTOR		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>10-4-71</u>		24C. NAME OF CEMETERY or PLACE OF INTERMENT <u>UNIVERSITY MEDICAL SCHOOL</u>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1971</u>		25B. NAME OF REGISTRAR <u>John E. Joyner</u>		25C. MORTUARY SERVICE <u>BCHD</u>		25D. ADDRESS	

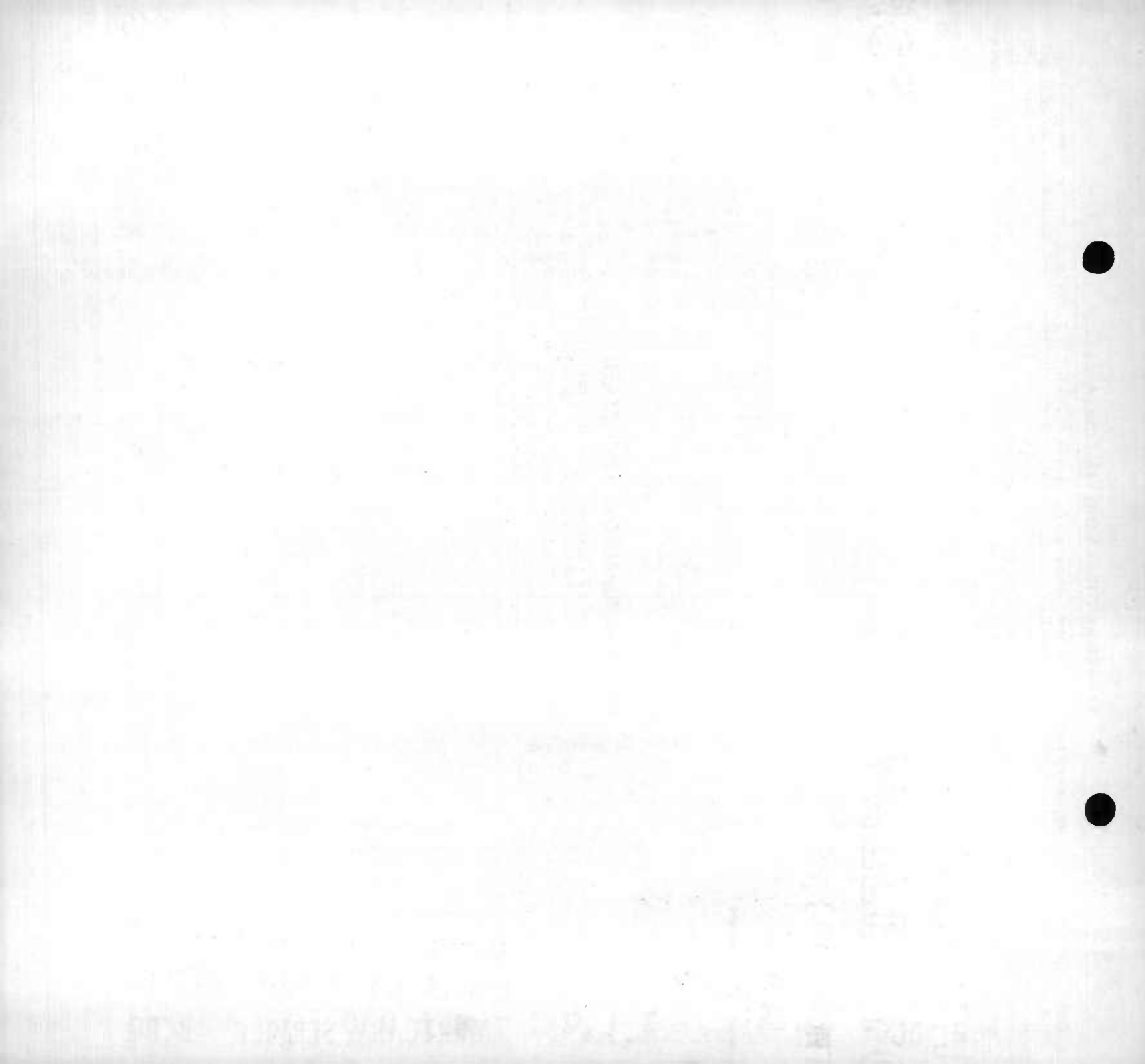




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 9194</b>	
W-320 BIRTH NO. <b>71-13395</b>		<b>9194</b>		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>BABY BOY WOODS</b>			2. DATE AND HOUR OF DEATH <b>8/13/71</b> <b>12:12 A</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>St. Joseph Hospital Baltimore, Md</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>AA</b> C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>456 GLEN MAR RD.</b>		
5. SEX <b>Male</b>	6. RACE <b>Can</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/13/71</b>	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <b>7</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>WOODS, John Arthur</b>			14. MOTHER'S MAIDEN NAME <b>LEDERHILBER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. <b>755.71</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hemorrhage from rupture congenital aneurysm of leg</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Born @ 12:05 AM 8/13/71</b> <b>Expired @ 12:12 AM 8/13/71</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>9-30-71</b>		24C. NAME OF CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<b>ANATOMY BOARD OF MARYLAND</b> <b>UNIVERSITY MEDICAL SCHOOL</b> <b>MORTUARY SERVICE - BCHD</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9195 4</span>	
L-563 <span style="font-size: 1.5em;">71-11608 9195</span>				CERTIFICATE OF DEATH	
BIRTH NO. <span style="font-size: 1.5em;">71-11608 9195</span>					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.5em;">BABY GIRL LEONARDI</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.5em;">7/8/71</span> <span style="float: right;">11:55 A.M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">42 Sinai Hospital</span>		A. STATE <span style="font-size: 1.5em;">BALTO</span>		B. COUNTY <span style="font-size: 1.5em;">5300</span>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <span style="font-size: 1.5em;">Beltz</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <span style="font-size: 1.5em;">307 Almond St 21221</span>			
5. SEX <span style="font-size: 1.5em;">F</span>	6. RACE <span style="font-size: 1.5em;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.5em;">7/8/71</span>	9. AGE (in years last birthday) <span style="font-size: 1.5em;">5.5</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">Sinai Hosp. Balt</span>	
13. FATHER'S NAME <span style="font-size: 1.5em;">FRANK K. Leonard</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">LORRAINE <del>XXXXXX</del> Dollar</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <span style="font-size: 1.5em;">776.2 I</span>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Cardiovascular arrest</span>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <span style="font-size: 1.5em;">Prematurity &amp; RDS</span> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">7/8/71</span> 19 <span style="font-size: 1.5em;">71</span> to <span style="font-size: 1.5em;">7/8/71</span> 19 <span style="font-size: 1.5em;">71</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">7/8</span> 19 <span style="font-size: 1.5em;">71</span> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Nozam Radfar, M.D.</span>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">NEZAM RADFAR, M.D.</span>		23D. ADDRESS <span style="font-size: 1.5em;">Sinai Hospital</span>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <span style="font-size: 1.5em;">9-30-71</span>		24C. NAME OF CEMETERY or CREMATOR <span style="font-size: 1.5em;">ANATOMY BOARD OF MARYLAND</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">OCT 4 1971</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Taylor</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">MORTUARY SERVICE - BCTD</span>	

James H. Smith

1850

1851

James H. Smith

James H. Smith

FRANK R. SMITH

James H. Smith

James H. Smith

James H. Smith

James H. Smith

James H. Smith

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9196</span>	
CERTIFICATE OF DEATH					
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">C-652 71-11679 9196</span> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Baby Girl Cornish A</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">12.02 AM 7/2/71</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">42 Sinai Hospital</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">1506</span> <b>5. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>6. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>7. STREET AND NUMBER</b> <span style="font-size: 1.2em;">2700 Baker Street 21216</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">F</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">N</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">7, 6, 71</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">35</span>	<b>10. Under 1 Yr. Months Days</b> <span style="font-size: 1.2em;">40</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Baltimore</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">MARVIN Cornish</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">BRENDA Cartwright</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT ADDRESS</b>	
<b>18. CAUSE OF DEATH</b>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Cardio respiratory arrest</span> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;"># yabie membrane disease</span>					
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">7/2</span> 1971 to <span style="font-size: 1.2em;">7/8</span> 1971 that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">11 PM 7/2</span> 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Nezam Radfar, M.D.</span>				<b>23B. DATE SIGNED</b>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <span style="font-size: 1.2em;">NEZAM RADFAR, M.D.</span>				<b>23D. ADDRESS</b>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b>		<b>24B. DATE</b> <span style="font-size: 1.2em;">9-30-71</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">OCT 4 1971</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor, D.D.</span>		<b>25C. FUNERAL DIRECTOR ADDRESS</b>	

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BOLD

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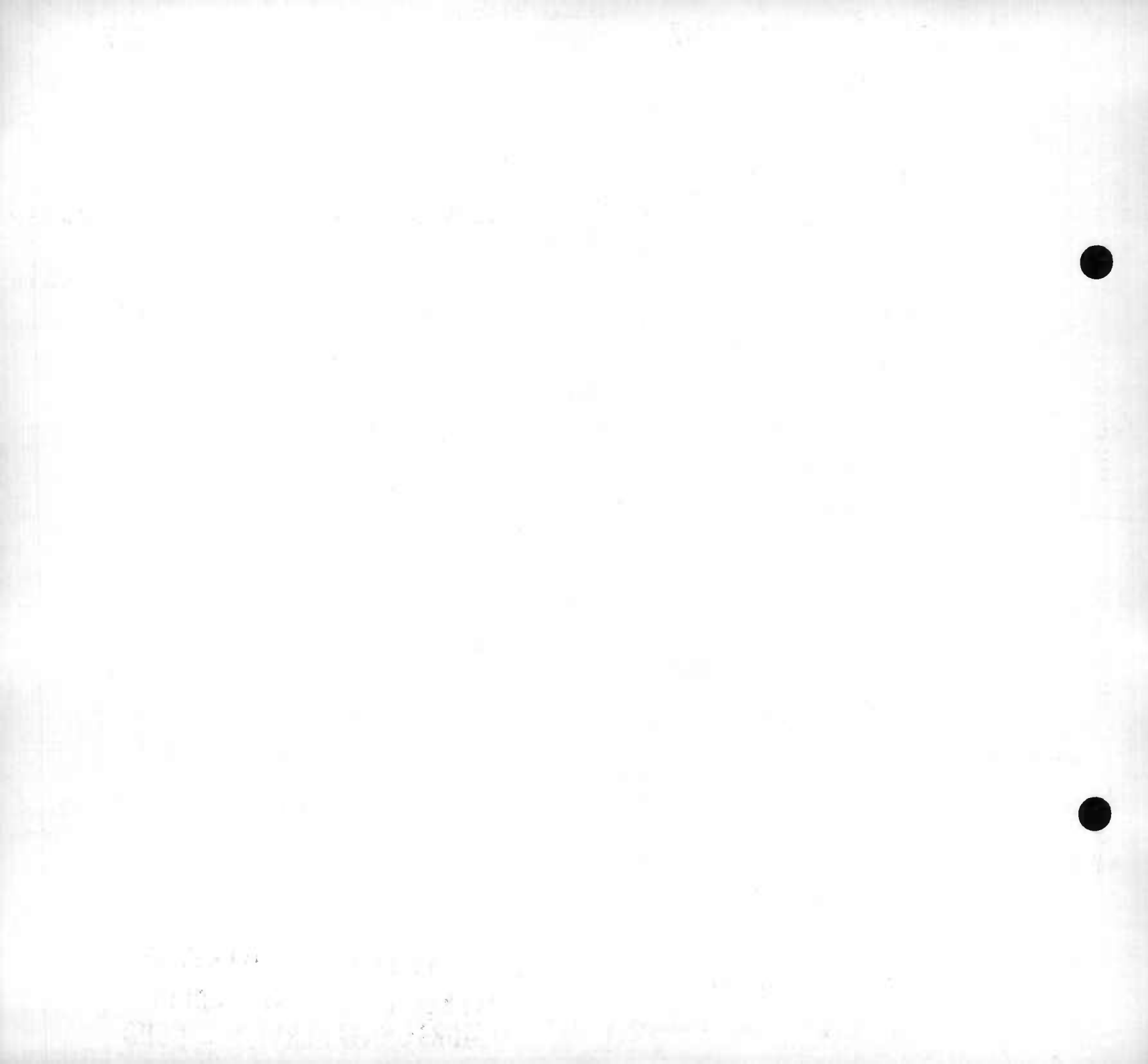
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9197</u>
BIRTH NO. <u>71-16078 9197</u>		1. NAME OF DECEASED (Type or Print) <u>BABY GIRL PEZOLD</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>9-21-71 10:00 P.M.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE. BELVEDERE AT GREENSPRING. BALTIMORE 21215.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>NEW BORN</u> B. COUNTY <u>BALTO 5300</u>		
5. SEX <u>F</u> 6. RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BABY</u>		8. DATE OF BIRTH <u>9-20-71</u> 9. AGE (In years last birthday) <u>24</u> 00		
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MARYLAND</u>		
13. FATHER'S NAME <u>Robert PEZOLD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Linda Harple</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. <u>776-9 I</u> CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> (A) IMMEDIATE CAUSE <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Anaemia</u>				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>October 20th 1971</u> to <u>October 21st 1971</u> that <u>(H)</u> (we) last saw the deceased alive on <u>October 21st 1971</u> and that <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.				
23A. SIGNATURE <u>A. White MB ChB</u>		23B. DATE SIGNED <u>9-21-71</u>		23C. PHYSICIAN'S NAME (Type) <u>Swan Hospital of Baltimore.</u>
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>9-20-71</u>		24C. NAME OF CEMETERY or REINTERMENT <u>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</u>
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9198</span>	
A-425 71 9198				BIRTH NO. <span style="font-size: 1.5em;">71-12822</span>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
<span style="font-size: 1.5em;">ALLISON, BABY GIRL</span>				<span style="font-size: 1.5em;">8/3/71</span> <span style="float: right;">7:15 A.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE <span style="font-size: 1.5em;">Maryland</span>	
<span style="font-size: 1.5em;">42 Briar Hospital of Baltimore</span>				C. CITY OR TOWN <span style="font-size: 1.5em;">Balto.</span>	
E. STREET AND NUMBER <span style="font-size: 1.5em;">4033 Annelles Rd. #15</span>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <span style="font-size: 1.5em;">F</span>		6. RACE <span style="font-size: 1.5em;">N</span>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.5em;">8/3/71</span>		9. AGE (In years last birthday)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<span style="font-size: 1.5em;">infant</span>		<span style="font-size: 1.5em;">not applicable</span>		<span style="font-size: 1.5em;">Maryland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.5em;">U.S.A.</span>				13. FATHER'S NAME <span style="font-size: 1.5em;">Frank Allison</span>	
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">Mary Lizzie</span>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
<span style="font-size: 1.5em;">no</span>				16. SOCIAL SECURITY NO. <span style="font-size: 1.5em;">—</span>	
17. INFORMANT <span style="font-size: 1.5em;">Mother's hospital chart</span>				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH	
<span style="font-size: 1.5em;">776.2 I</span>				<span style="font-size: 1.5em;">Respiratory distress</span>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				<span style="font-size: 1.5em;">Prematurity</span>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.5em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.5em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">8/3</span> <span style="font-size: 1.5em;">8/3</span> 19 <span style="font-size: 1.5em;">71</span> to <span style="font-size: 1.5em;">8/3</span> 19 <span style="font-size: 1.5em;">71</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">8/3</span> 19 <span style="font-size: 1.5em;">71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">A. Marcand</span>				23B. DATE SIGNED <span style="font-size: 1.5em;">8/3/71</span>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE <span style="font-size: 1.5em;">9-30-71</span>	
24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR				ADDRESS	

**ANATOMY BOARD OF MARYLAND**  
**UNIVERSITY MEDICAL SCHOOL**  
**MORTUARY SERVICE - BCHD**



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="background-color: black; color: black;">[REDACTED]</span>
11-324-1314071 9199		71 9199		
BIRTH NO.		71 9199		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
MITCHELL BABY BOY B		7/3/71 8:38 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
SINAI HOSPITAL OF BALTIMORE INC.		MARYLAND 1510		
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		3832 BOARMAN AVE.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (Month-Day-Year)	9. AGE (in years Most birthday)
MALE	N		7/3/71	3
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
				SINAI HOSP. OF BALTO. INC.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		
YES		Stephen Baunick		
		14. MOTHER'S MAIDEN NAME		
		FAVE Mitchell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. 769.4 I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		RESPIRATORY FAILURE 15min		
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		PREMATURITY		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		TWIN 43"		
		(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
2				Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 6/29/71 to 7/3/71 that (I) (we) last saw the deceased alive on 7/3/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
Duchala Muzhabhuma M.D.				7/3/71
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY
		9-30-71		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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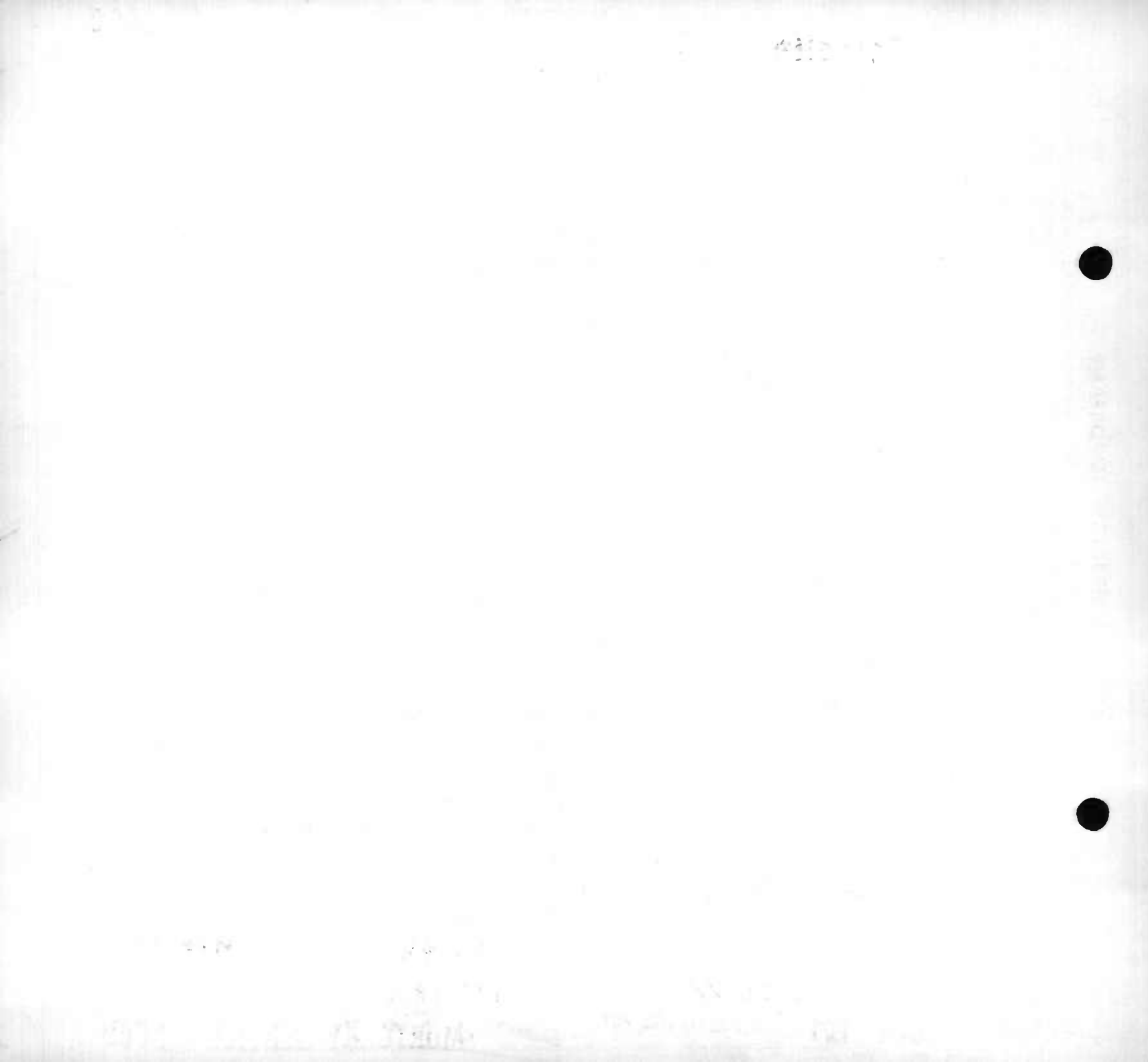
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9201</u>
BIRTH NO. <u>B-346 71 9201</u>				CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <u>BUTLER BABY GIRL DIANE</u>		2. DATE AND HOUR OF DEATH <u>9. 16. 71</u> <u>9-55 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL OF BALTIMORE</u> <u>42</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2864</u> C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>204 DIENER PLACE</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-12-71</u>	9. AGE (In years last birthday) <u>4</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>AARON BUTLER</u>		
14. MOTHER'S MAIDEN NAME <u>DIANE</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. <u>748-2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>MASSIVE PULMONARY AND</u> <u>(A) IMMEDIATE CAUSE INTRAVENTRICULAR HAEMMORHAGE</u> DUE TO, OR AS A CONSEQUENCE OF: <u>PREMATURITY</u> DUE TO, OR AS A CONSEQUENCE OF: <u>(B) PREMATURITY</u> DUE TO, OR AS A CONSEQUENCE OF: <u>(C)</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>9-12-1971</u> to <u>9-16-1971</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>9-16-1971</u> and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.		
23A. SIGNATURE <u>Arun K. Pramanik</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9. 16. 71</u>		
23C. PHYSICIAN'S NAME (Type) <u>ARUN K. PRAMANIK, M.D.</u>		23D. ADDRESS <u>Sinai Hospital of Baltimore</u> <b>ANATOMY BOARD OF MARYLAND</b> <b>UNIVERSITY MEDICAL SCHOOL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>9-30-71</u>		24B. DATE		24C. NAME of CEMETERY or CREMATOR <u>MORTUARY SERVICE - BCHD</u>
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS		





## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

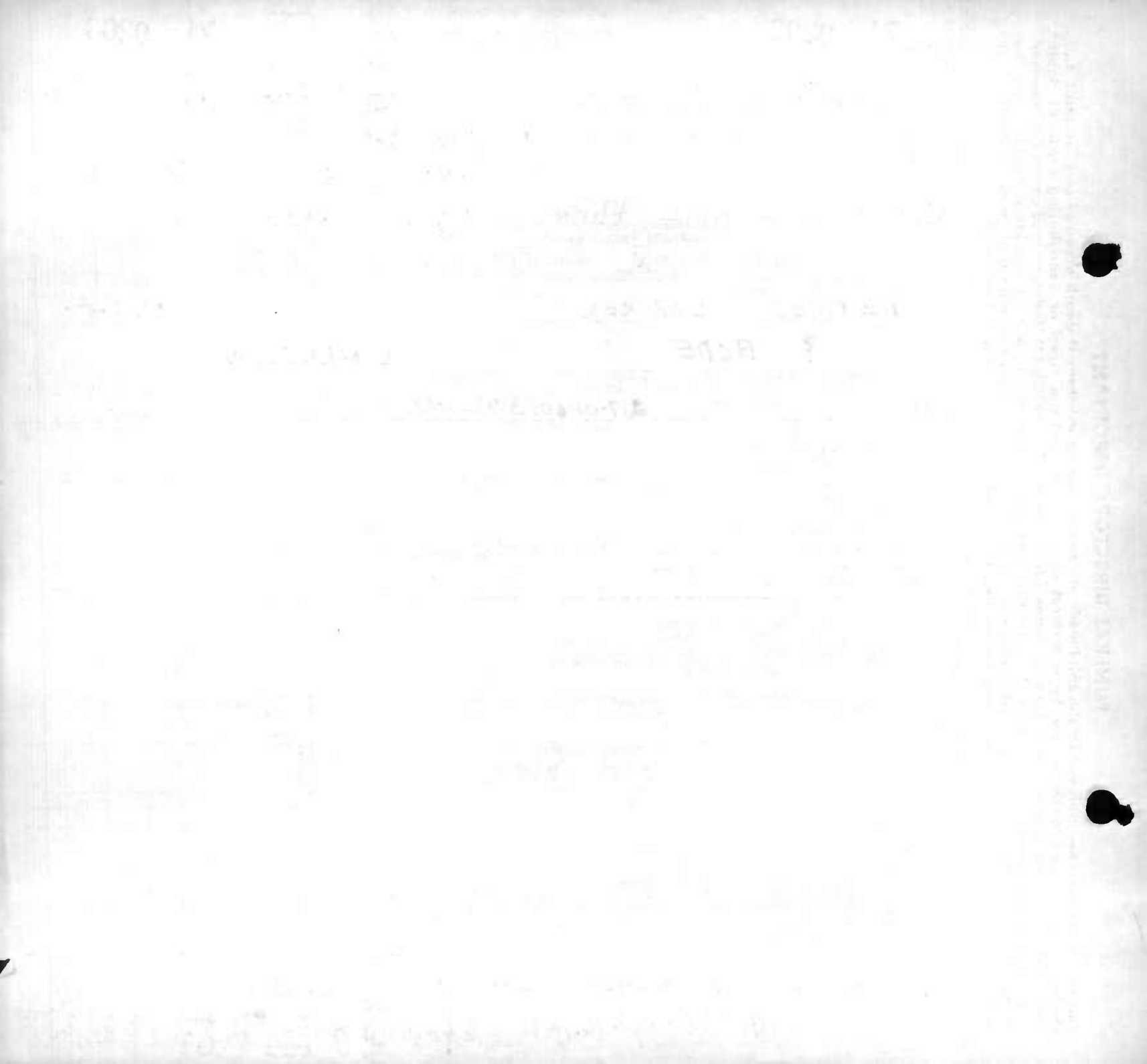
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 9202	
Z-200 71 9202					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>MARCVANNA ZYCH</b>			2. DATE AND HOUR OF DEATH <b>9/30/71 7:45 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospital</b>			A. STATE <b>Maryland</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore, Md. 21224</b>			B. COUNTY <b>2605</b>		
C. CITY OR TOWN <b>Maryland</b>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>304 Elrino St. 21224 007</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-11-90</b>	9. AGE (in years last birthday) <b>80</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <b>Poland</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Janalau WASILEWSKI</b>			14. MOTHER'S MAIDEN NAME <b>Josephine WOTKOWIA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO. <b>217-05-2049</b>		
17. INFORMANT <b>BCH-Records Baltimore, Maryland 21224</b>			ADDRESS		
18. <b>250.9 I</b>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiopulmonary arrest</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF: <b>3 hours</b>		
			(C) <b>Diabetes Mellitus</b> <b>10 yrs</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/30 3PM 1971</b> to <b>9/30 1971</b> that (I) (we) last saw the deceased alive on <b>9/30/71 7:45 PM</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dan Tartagha MD</b>			23B. DATE SIGNED <b>9/30/71</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>Dan Tartagha MD</b>			23D. ADDRESS <b>BCH - 4940 Eastern Avenue Baltimore, Md. 21224</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<b>BURIAL 10-4-71</b>		<b>10-4-71</b>		<b>Holy Rosary Cem. Dundalk, Balt. Md.</b>	
25A. DATE REC'D. BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<b>OCT 4 1971</b>		<b>John M. Weber</b>		<b>John M. Weber &amp; Sons Inc. S. Chester</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9203</u>	
BIRTH NO. <u>71 9203</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>ADAM J. BODE</u>			2. DATE AND HOUR OF DEATH <u>OCTOBER 2 1971, 3:15 A. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2731</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 UNION MEMORIAL HOSP.</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>4900 BELAIR ROAD</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 13, 1893</u>	9. AGE (In years last birthday) <u>(78) 88</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>LABORER</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>	
13. FATHER'S NAME <u>? BODE</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>217-01-6053</u>			17. INFORMANT <u>WILLIAM C. BODE</u> ADDRESS <u>4023 ST. AUGUSTINE LANE, BALTO., 21224, MD.</u>		
18. <u>433.9 I</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>BRONCHOPNEUMONIA</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) <u>CEREBRAL THROMBOSIS</u> (C) <u>ARTERIO-SCLEROSIS</u>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 27 1971</u> to <u>OCTOBER 2 1971</u> that (I) (we) last saw the deceased alive on <u>OCTOBER 2 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>10/2/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>CESAR VILLARDIN</u>				23D. ADDRESS <u>33rd. and Calvert St.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10-5-71</u>		24C. NAME of CEMETERY or CREMATORY <u>MEADOWRIDGE CEM.</u>	
24D. LOCATION <u>ELKRIDGE, MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1971</u>			
25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>901 S. CONKLING ST. BALTO., 21224, MD.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-520 71 9204		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9204	
BIRTH NO. <i>Sadie Thomas</i>		1. NAME OF DECEASED (Type or Print) <b>THOMAS, Sadie Elizabeth</b>		2. DATE AND HOUR OF DEATH <i>Oct 1 1971</i> <i>11:10 AM</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Johns Hopkins Hospital</i> <i>33</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <i>501</i>		C. CITY OR TOWN <b>Baltimore</b>	
5. SEX <i>F</i>		6. RACE <i>N N</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>4/19/88</i>		9. AGE (In years last birthday) <i>83</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <b>Henry Thaddeus</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Henry</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Nattie Lee - 1412 N. Bittel St.</i>	
18. <i>477.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pulmonary Edema</i> (B) <i>Consecutive heart failure</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i> <i>12 hours</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>10-1-71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>no</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>6-30-71</i> 19 <i>71</i> to <i>10-1-71</i> 19 <i>71</i> that (I) (we) lost saw the deceased alive on <i>10-1-71</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Walter Matthew Malloy</i>		23B. DATE SIGNED <i>10-1-71</i>		23C. PHYSICIAN'S NAME (Type) <b>Walter Matthew Malloy, M.D.</b>	
23D. ADDRESS <b>The Johns Hopkins Hospital</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			
24B. DATE <i>10-6-71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Int. Auburn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>3 Westport, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 4 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. J. J. J.</i>		25C. FUNERAL DIRECTOR <i>Edw. H. N. 1129 N. Caroline St.</i>	



1

S-425 71 9205

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9205

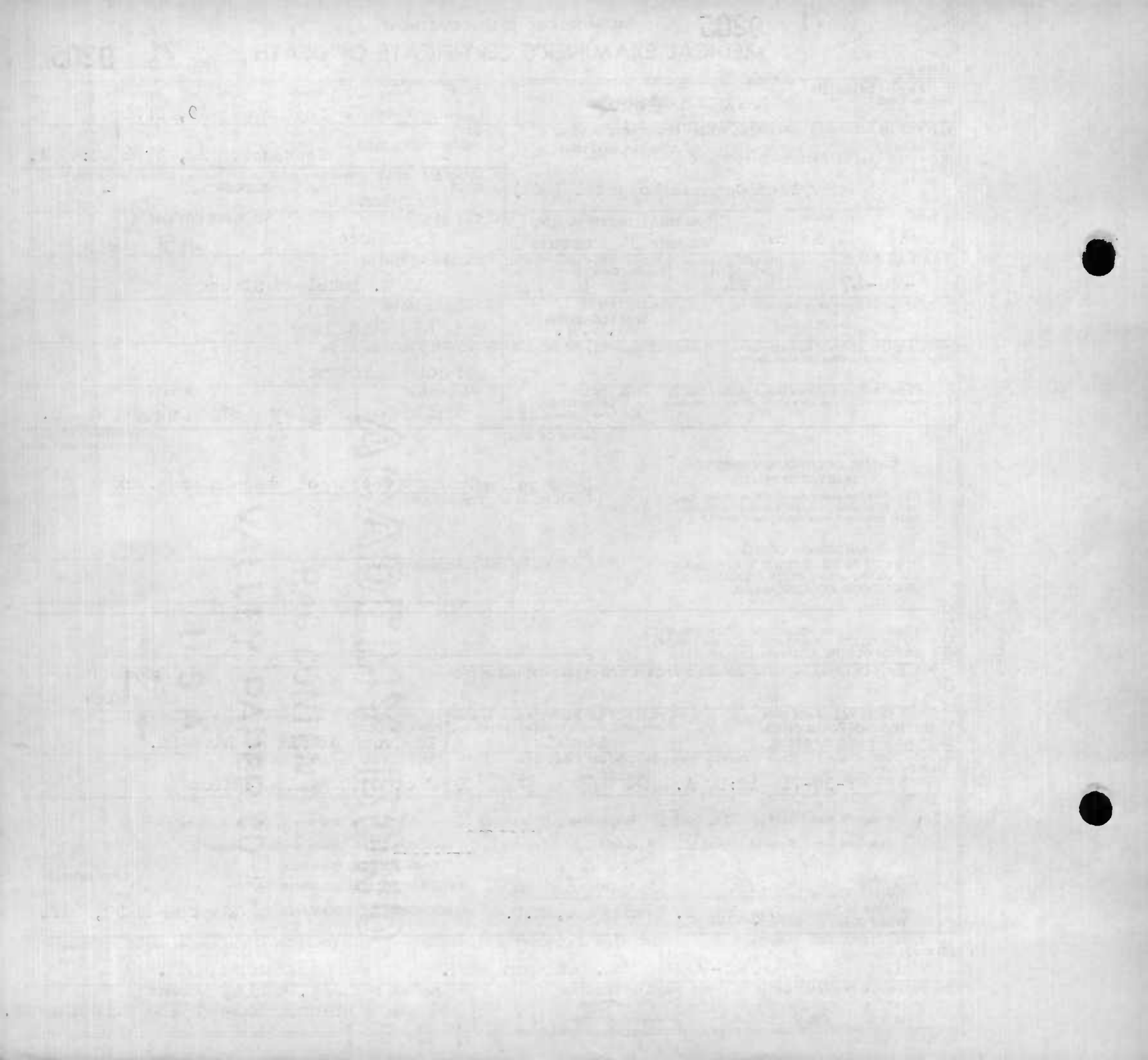
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LAWRENCE Slocum</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> <b>September 30, 1971</b>		Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD <b>September 30, 1971 12:45 A.M.</b>		Month Day Year Hour	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1606</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>815 N. Dukeland Street</b>	
9. DATE OF BIRTH <b>1-26-47</b>		10. AGE (In years lost birthday) <b>24</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>Phillip Ridgley</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>14B. KIND OF BUSINESS OR INDUSTRY</b>	
15. MOTHER'S MAIDEN NAME <b>Dorothy Slocum</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>215-52-2224</b>	
18. INFORMANT <b>Phillip Ridgley</b>		ADDRESS <b>815 Dukeland St.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <b>F 765X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Gunshot wounds of abdomen and back</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>sidewalk</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>In front of 511 W. Blum St. Bloom 1403</b>	
22D. TIME OF INJURY (APPROX.) <b>9-30-71 12:30 A.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot during altercation</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type): <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: <b>September 30, 1971</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-4-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1971</b>		25B. NAME OF REGISTRAR <b>Robert L. [illegible]</b>	
25C. FUNERAL DIRECTOR <b>V. Bailey</b>		ADDRESS <b>Kelson Funeral Home 1348 Calhoun St.</b>			

VS 151-REV. 7/1/68

4201







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 9206</u>	
4-200 71 9206		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>HICKS, EARL C.</u>		10-2-71 6:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital</u> <u>Baltimore, Md. 21216</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>1501</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1632 BALMOR COURT</u>	
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-8-86</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>minister</u>		9. AGE (In years last birthday) <u>85</u>	11. BIRTHPLACE (State or foreign country) <u>Texas</u>
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>553-50-4770</u>	
		17. INFORMANT (Friend) <u>Helen DUVALL</u> ADDRESS <u>Same</u>	
18. <u>436.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CVA (Cerebrovascular Accident)</u> (B) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF: <u>17 days</u> (C) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF: <u>17 days</u> <u>17 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>9-14-</u> 19 <u>71</u> to <u>10-2-</u> 19 <u>71</u> that (1) <u>we</u> last saw the deceased alive on <u>10-2-</u> 19 <u>71</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>we</u> (did) (did not) view the body after death.			
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>10-2-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>JASON SAMUEL</u> M.D.		23D. ADDRESS <u>Lutheran Hospital, 1501 73rd, Ashburton St., Baltimore MD 21216.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10-7-71</u>	24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Pk.</u>	24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1971</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	25C. FUNERAL DIRECTOR <u>V. Bailey</u>	ADDRESS <u>Kelson O. Ho 1348 Calhoun St.</u>



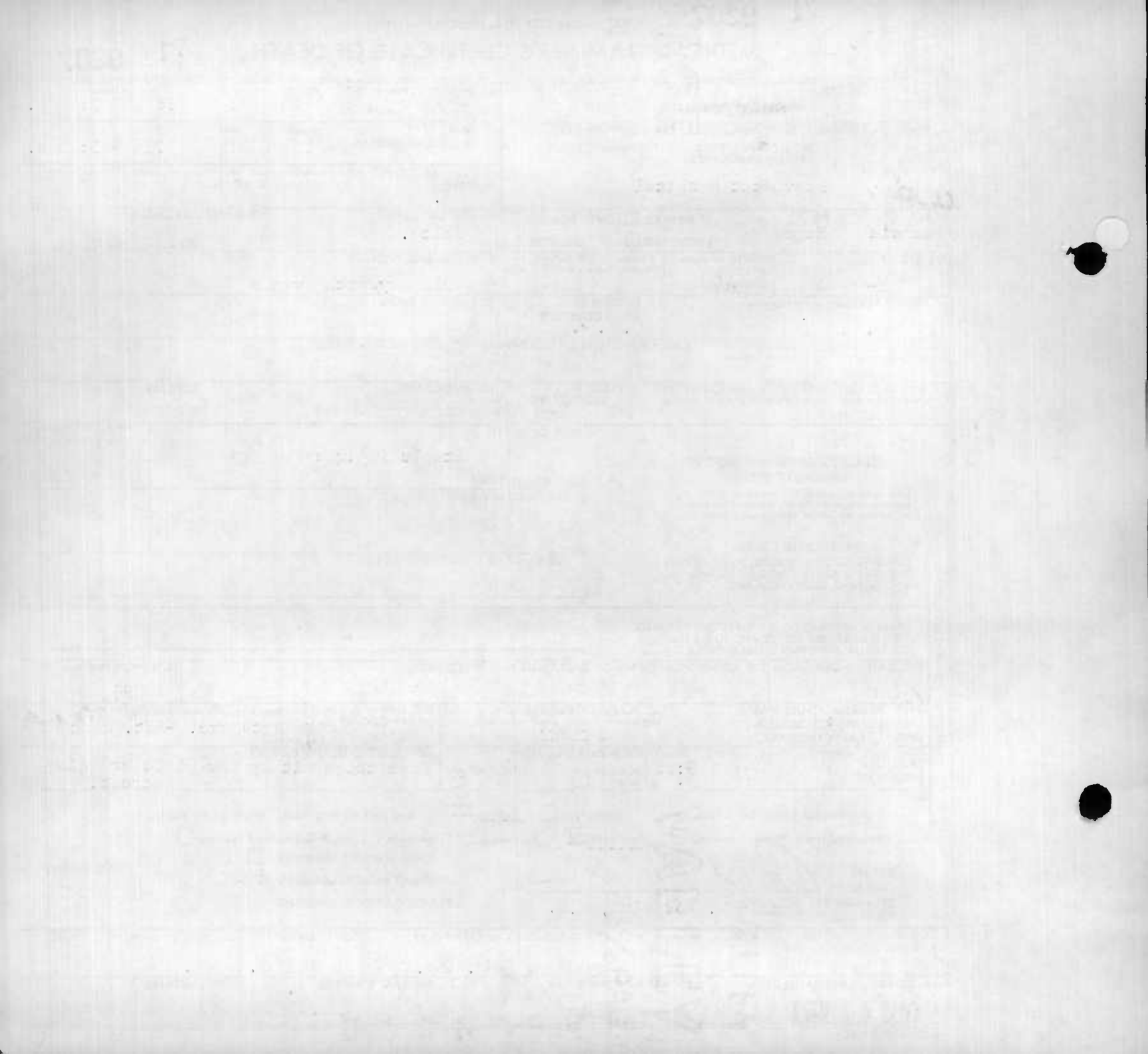
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 9207

BIRTH NO.

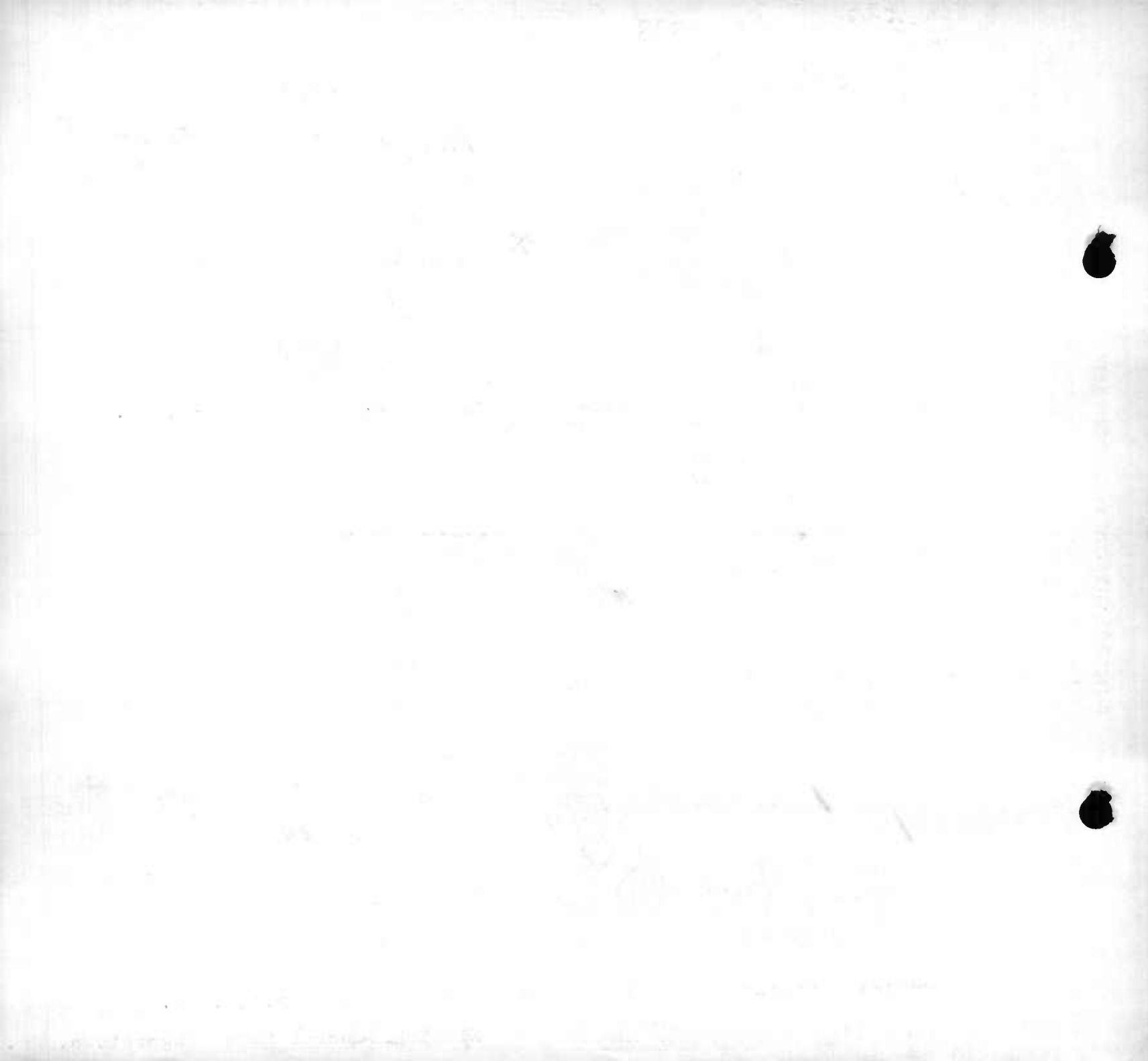
1. NAME OF DECEASED (Type or Print) Annie Laura Payne		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 2 Year 71 Hour 3:15 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital		3. DATE PRONOUNCED DEAD Month 10 Day 2 Year 71 Hour 3:15 a.m.	
6. SEX female		7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH 8-6-24		10. AGE (in years last birthday) 47	11. BIRTHPLACE (State or foreign country) S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 215-22-1366	
18. INFORMANT Walter Payne		ADDRESS same	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Park Hgts Ave. -6ft. south of Hillman Avenue		22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) 10 1 71 9:55 p.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Pedestrian hit by car while crossing street.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/2/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-6-71	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1971		25B. NAME OF REGISTRAR Robert C. Taylor, Jr.	
25C. FUNERAL DIRECTOR V. Bailey		ADDRESS Kelson F.H. 1348 Calhoun Street	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

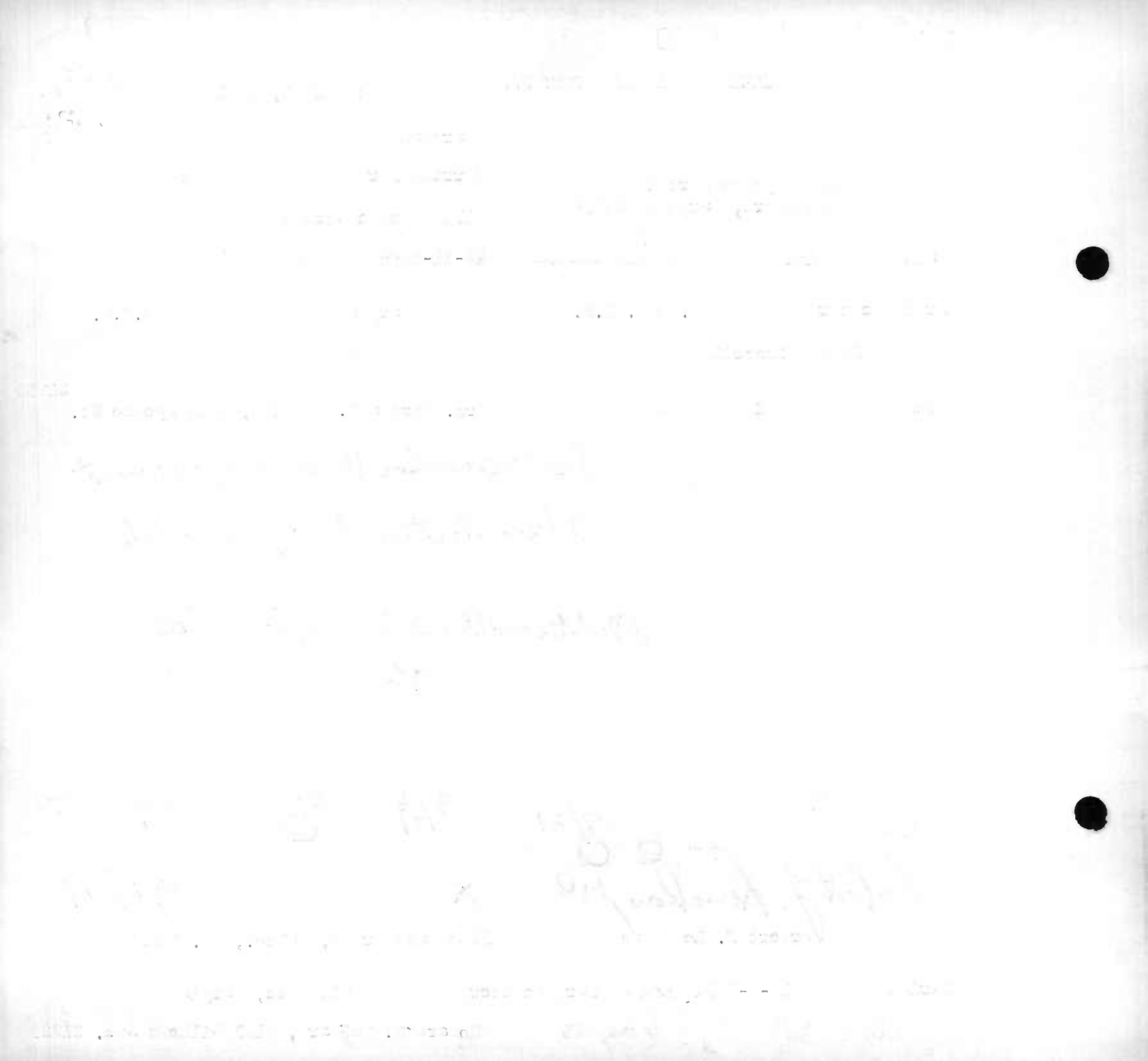
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9208</u>	
<b>B-530</b> <b>BIRTH NO.</b> <u>Hagerstown, Md.</u> <b>1. NAME OF DECEASED</b> (Type or Print) <u>BOND, Robin</u>		<b>CERTIFICATE OF DEATH</b>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <u>Johns Hopkins Hospital</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>9/29/71 5:00 PM</u> <b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>WASHINGTON</u> <b>C. CITY OR TOWN</b> <u>Hagerstown, Md.</u> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>Rt 1 Box 108-A</u>			
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>11/25/70</u>		<b>9. AGE</b> (in years last birthday) <u>10</u>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Hagerstown, Md.</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>
<b>13. FATHER'S NAME</b> <u>Joseph Bond</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Connie Bond</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> <u>Joseph Bond</u> <b>ADDRESS</b> <u>Hagerstown, Md.</u>	
<b>18. CAUSE OF DEATH</b>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>(A) IMMEDIATE CAUSE</b> <u>Renal Failure</u> <b>DUE TO, OR AS A CONSEQUENCE OF:</b>  <b>(B) <u>Liver Failure</u></b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <u>Biliary Atresia</u> <b>(C)</b>	
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <u>9/17/71</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <u>Biliary Atresia</u>		<b>20A. AUTOPSY?</b> (Yes or No) <u>No</u>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that</b> <input checked="" type="checkbox"/> <b>(this hospital)</b> attended the deceased from <u>9/29/71</u> 19__ to <u>9/29/71</u> 19__ that <input checked="" type="checkbox"/> <b>(we)</b> last saw the deceased alive on <u>9/29/71</u> 19__ and that <input checked="" type="checkbox"/> <b>(my)</b> <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> <b>(We)</b> <b>(did)</b> <b>(did not)</b> view the body after death.					
<b>23A. SIGNATURE</b> <u>Thomas Hoffman MD</u>				<b>23B. DATE SIGNED</b> <u>9/29/71</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>Thomas Hoffman MD</u>		<b>23D. ADDRESS</b> <u>Johns Hopkins Hosp</u>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>burial</u>		<b>24B. DATE</b> <u>10-2-71</u>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>Rest Haven Cemetery</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Hagerstown, Md.</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>OCT 4 1971</u>			
<b>25B. NAME OF REGISTRAR</b> <u>BASE REG. #20000</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Minnich Funeral Home</u>			
<b>ADDRESS</b> <u>Hagerstown, Md.</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9209</span>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">WILLIAM JAMES RUSSELL</span>		<b>2. DATE AND HOUR OF DEATH</b> October 1, 1971 <span style="float: right;">3:55 P.M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <div style="text-align: center; font-size: 1.5em;">00</div> 1714 Spence Street Baltimore, Maryland 21230		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">2553</span> <b>C. CITY OR TOWN</b> Morrell Park <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> 1714 Spence Street		
<b>5. SEX</b> Male	<b>6. RACE</b> White	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 10-11-1890	<b>9. AGE</b> (In years last birthday) 80 If Under 1 Yr. Months:    Days:    If Under 24 Hrs. Hours:    Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Car Inspector		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> B. & O. R.R.		<b>11. BIRTHPLACE</b> (State or foreign country) Maryland
<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.		<b>13. FATHER'S NAME</b> John Russell		
<b>14. MOTHER'S MAIDEN NAME</b> Unknown		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) Yes <span style="margin-left: 100px;">W W I</span>		
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Mrs. Bertha H. Russell, 1714 Spence St.		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">Cerebrovascular thrombosis, recurrent</span> DUE TO, OR AS A CONSEQUENCE OF: (B) <span style="font-size: 1.2em;">Arteriosclerotic CVD, advanced</span> DUE TO, OR AS A CONSEQUENCE OF: (C)		
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <span style="font-size: 1.2em;">Diabetes mellitus &amp; Chronic pyelonephritis</span>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>		
<b>19A. DATE OF OPERATION</b> 0	<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>	<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.5em;">No</span>	<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)	<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		
<b>21D. TIME OF INJURY</b> (Approx.) (Month) (Day) (Year) (Hour)	<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	<b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that</b> (1) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3/6</span> 19 <span style="font-size: 1.2em;">67</span> to <span style="font-size: 1.2em;">10/1</span> 19 <span style="font-size: 1.2em;">71</span> that (1) (we) last saw the deceased alive on <span style="font-size: 1.2em;">9/28</span> 19 <span style="font-size: 1.2em;">71</span> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Herbert J. Levickas, M.D.</span>		<b>23B. DATE SIGNED</b> <span style="font-size: 1.5em;">10/1/71</span>		<b>23C. PHYSICIAN'S NAME</b> (Type) Herbert J. Levickas
<b>23D. ADDRESS</b> 5404 East Drive, Balto., Md. 21227		<b>24A. BURIAL, CREMATION, REMOVAL (Specify)</b> Burial		
<b>24B. DATE</b> 10-4-1971	<b>24C. NAME OF CEMETERY or CREMATORY</b> Loudon Park Cemetery		<b>24D. LOCATION</b> (City, town, or county) (State) Baltimore, Maryland	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.5em;">OCT 4 1971</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>		<b>25C. FUNERAL DIRECTOR</b> Howard H. Hubbard, 4107 Wilkens Ave. 21229



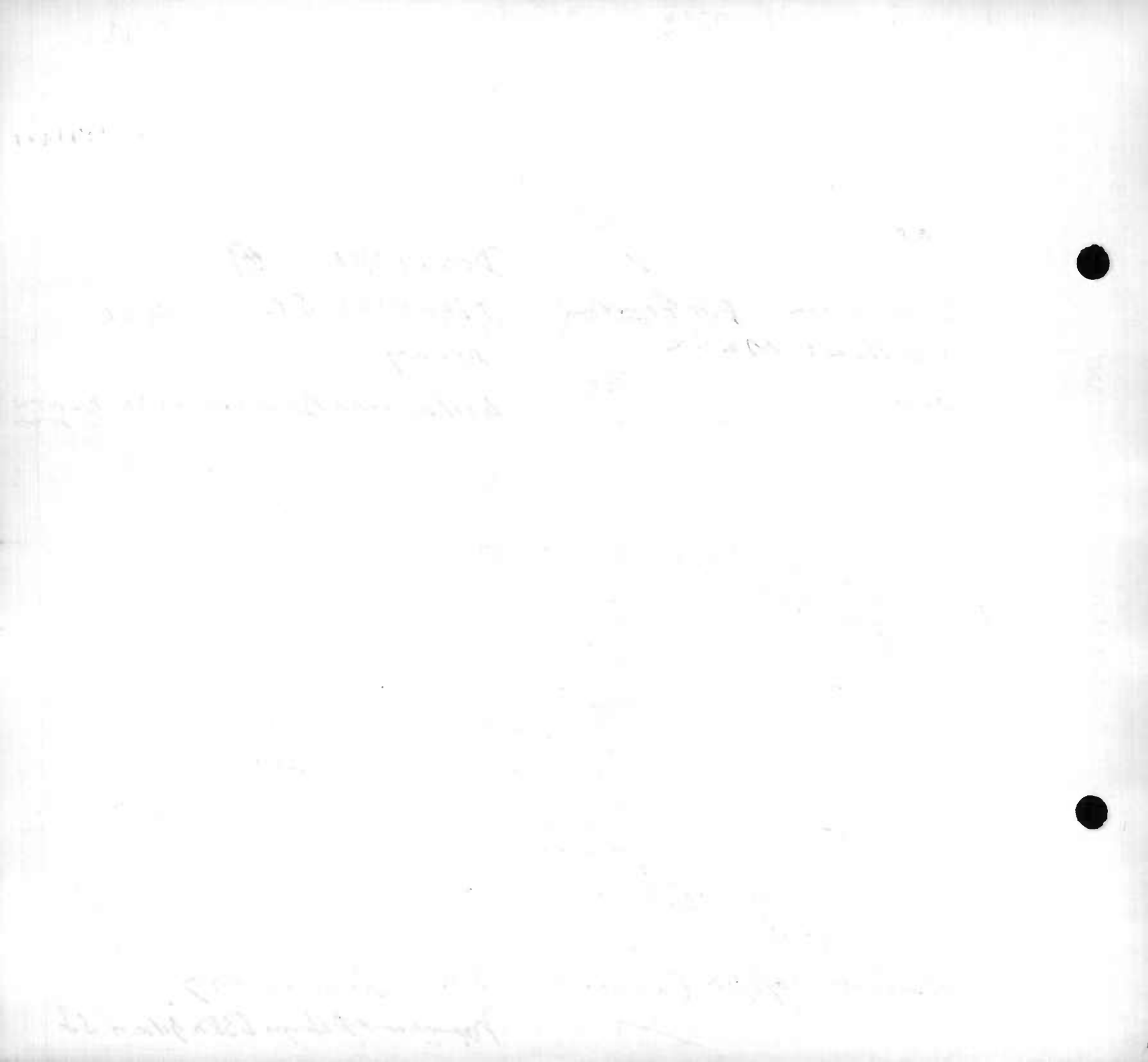


BIRTH NO.		71 9210		BALTIMORE CITY HEALTH DEPARTMENT		71 9210	
1. NAME OF DECEASED (Type or Print) Lydia C. Deese				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 10 Day 3 Year 71 Hour 7:35 a. M. Estimated <input type="checkbox"/> Month 10 Day 3 Year 71 Hour 7:35 a. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 So. Balto. Gen. Hospital				3. DATE PRONOUNCED DEAD Month 10 Day 3 Year 71 Hour 7:35 a. M.			
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Va. B. COUNTY V 43							
6. SEX female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Hopewell		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 12-27-1894		10. AGE (In years last birthday) 77	11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Lawson L. Smith		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Sally L. Handsel		16. SOCIAL SECURITY NO. 225-42-7854	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		18. INFORMANT Mrs. Hugh Myers		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/3/71							
24A. BURIAL CREMATION, REMOVAL (Specify) Rem.-Burial		24B. DATE 10-4-71		24C. NAME OF CEMETERY or CREMATORY Blandford		24D. LOCATION (City, town, or county) (State) Petersburg Va.	
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co., Balto., Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>71 9211</b>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <i>Eva Johnson</i>		<b>2. DATE AND HOUR OF DEATH</b> <i>Oct. 2, 1971 1:41 A.M.</i>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>46 Lutheran Hospital</i>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1506</i>  <b>C. CITY OR TOWN</b> <i>Baltimore</i> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  <b>E. STREET AND NUMBER</b> <i>3009 W. North Av.</i>		
<b>5. SEX</b> <i>F</i>	<b>6. RACE</b> <i>B</i>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <i>Dec 24, 1901</i>	<b>9. AGE</b> (In years last birthday) <i>69</i>	<b>If Under 1 Yr.</b> Months Days <b>If Under 24 Hrs.</b> Hours Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <i>Part Family</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>MANNING SC</i>	
<b>13. FATHER'S NAME</b> <i>Collins Mack</i>			<b>14. MOTHER'S MAIDEN NAME</b> <i>Mary</i>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <i>Williamson Bannan</i>
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>I</b> <b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>			<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>(A) IMMEDIATE CAUSE</b> <i>Myocardial Infarction</i> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) Arteriosclerotic Heart Disease</b> <i>Unknown</i> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C)</b>		
<b>MEDICAL CERTIFICATION</b>					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <i>no</i>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/> <i>no</i>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>approx. 1967</i> <b>19</b> <i>10/2</i> <b>19</b> <i>71</i> <b>that (I) (we) last saw the deceased alive on</b> <i>10/1</i> <b>19</b> <i>71</i> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <i>D. W. Stewart, M.D.</i>				<b>23B. DATE SIGNED</b> <i>10/2/71</i>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <i>D. W. STEWART, M.D.</i>		<b>23D. ADDRESS</b> <i>2300 Garrison Blvd</i>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <i>Buried</i>		<b>24B. DATE</b> <i>10/2/71</i>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <i>Cannon Mount Park</i>	
<b>24D. LOCATION</b> (City, town, or county) (State) <i>Lanora MD</i>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <i>OCT 4 1971</i>			
<b>25B. NAME OF REGISTRAR</b>		<b>25C. FUNERAL DIRECTOR</b>		<b>ADDRESS</b> <i>1382 Gilman St</i>	



S-300

BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH71 9212  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

James Price Scott

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐Month  
10Day  
1Year  
71Hour  
4:40

P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

34 Bon Secours Hospital

3. DATE  
PRONOUNCED DEADMonth  
10Day  
1Year  
71Hour  
4:40

P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Md. B. COUNTY 1503

6. SEX

male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Nov 13-1948

10. AGE (In years  
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1706 Thomas Avenue

11. BIRTHPLACE (State or foreign country)

BALTO MD

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Bunoy Harrison

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

LABORER

14B. KIND OF BUSINESS OR INDUSTRY

CITY BALTO

15. MOTHER'S MAIDEN NAME

Della M. Scott

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

217-53-7904

18. INFORMANT

Della M. Scott 5306 Preston St

ADDRESS

19.

304.9 I

CAUSE OF DEATH

Intravenous narcotism

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

1

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
10/2/7124A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10/6/71

24C. NAME OF CEMETERY or CREMATORY

Mt Arson

24D. LOCATION (City, town, or county)

BALTO MD

(State)

25A. DATE REC'D BY HEALTH DEPT.

OCT 4 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Mary Ann P. Hays 638 N. Gilmor St

ADDRESS

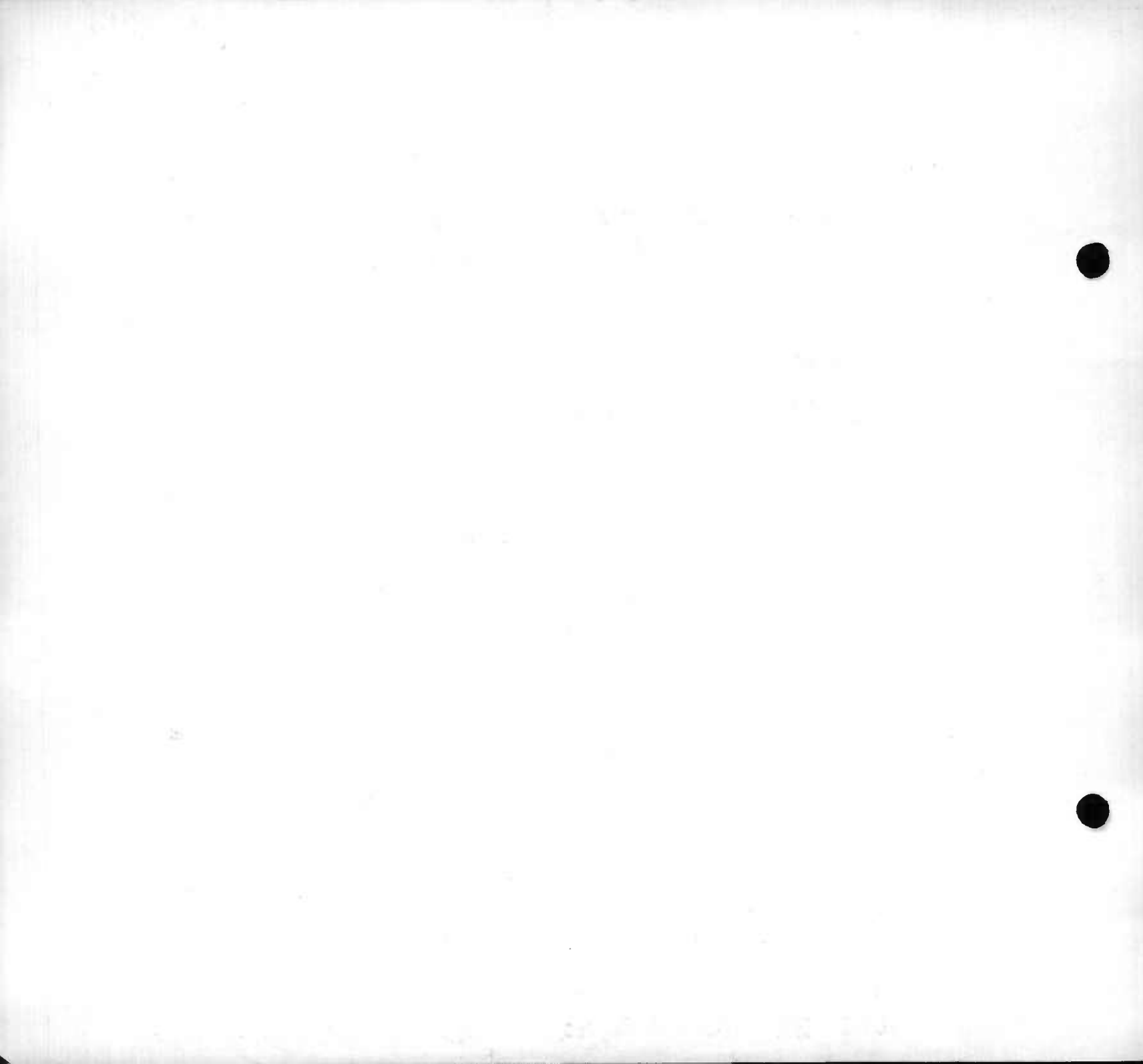
1150 N 11

1150 N 11

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>71 9213</b>
BIRTH NO. <b>71 9213</b>		1. NAME OF DECEASED (Type or Print) <b>John Lettner</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <b>Oct. 3, 1971 4:45 P.M.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Bon Secours Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2003</b>		
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>3-5-83</b> 9. AGE (in years last birthday) <b>88</b>
13. FATHER'S NAME <b>Andrew</b>		14. MOTHER'S MAIDEN NAME		11. BIRTHPLACE (State or foreign country) <b>Germany</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216 42-2138</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>
17. INFORMANT <b>Mrs. J. Lettner</b>		ADDRESS <b>1075 Payson St.</b>		
18. <b>4-10-91-201X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute MI.</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD.</b>		
19. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Hodgkins Disease ?</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 16 1971</b> to <b>October 3 1971</b> that (I) (we) last saw the deceased alive on <b>Oct 3 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Somchai Werasophon M.D.</b>		23B. DATE SIGNED <b>10/3/71</b>		23C. PHYSICIAN'S NAME (Typo) <b>SOMCHAI WERASOPHON</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/6/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>		25C. FUNERAL DIRECTOR <b>Wm. J. Schwartz, Jr.</b>
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		24E. ADDRESS		





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED  
(Type or Print)

WANDA LUTTRELL

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Sinai Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

10

3

1971

12:35 p.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md.

6. SEX

female

7. RACE

white

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

July 8, 1932

10. AGE (in years  
lost birthday)

39

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3255 Chestnut Ave.

11. BIRTHPLACE (State or foreign country)

Tennessee

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Fred A. Bivens

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Margaret McCall

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

Akard Funeral Home

ADDRESS

Bristol Tenn.

19. *E9651*

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Shotgun wounds of chest and neck

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

church

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Mt. Wash. Methodist Church

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

10-3-71

10:25 a.m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot by husband.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10-4-71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10/8/71

24C. NAME OF CEMETERY or CREMATORY

Mountain View

24D. LOCATION (City, town, or county)

Bristol, Va.

(State)

25A. DATE REC'D BY HEALTH DEPT.

OCT 5 1971

25B. NAME OF REGISTRAR

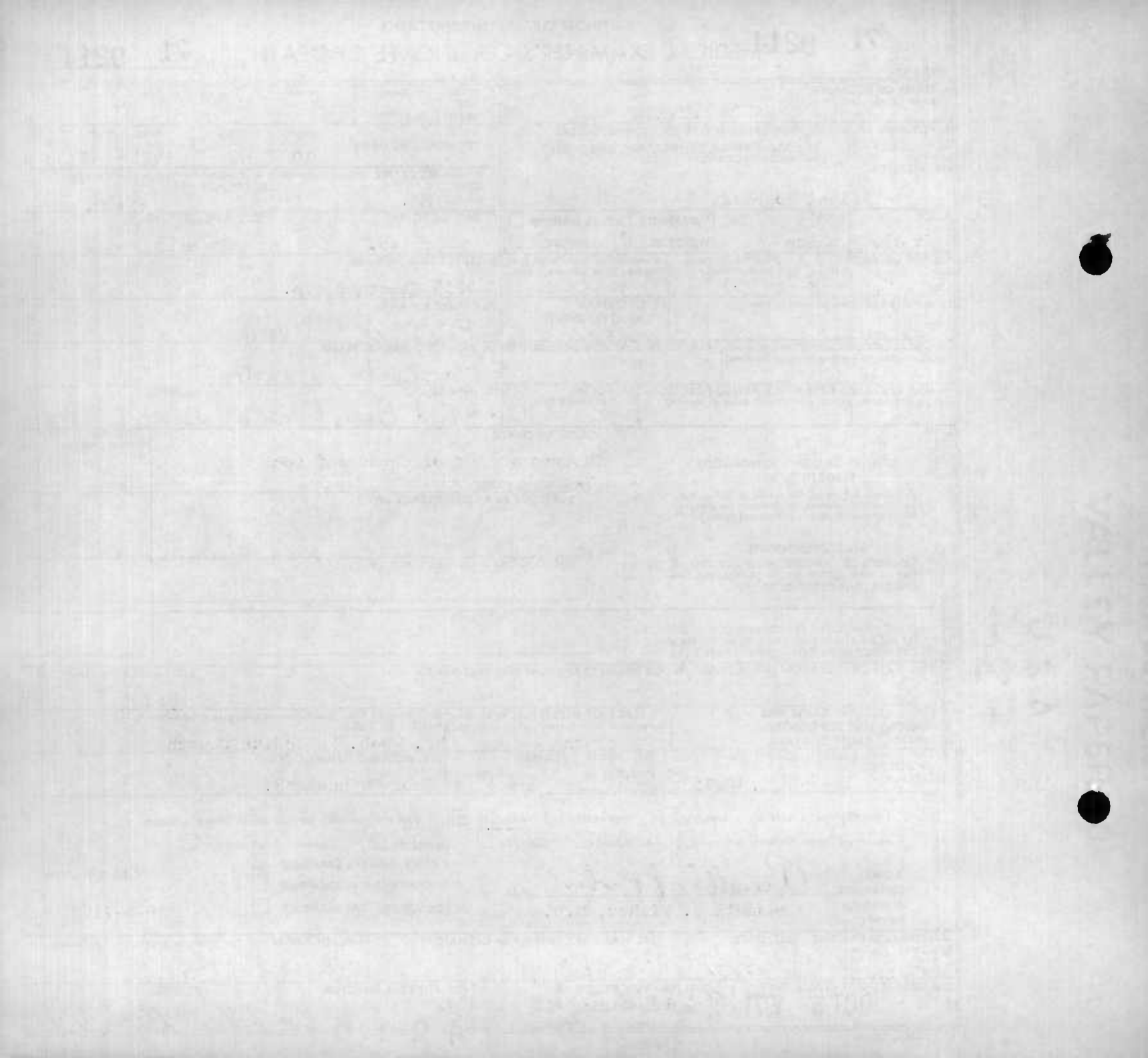
Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

George L. Schwartz, Jr.

ADDRESS

Baltimore, Md.

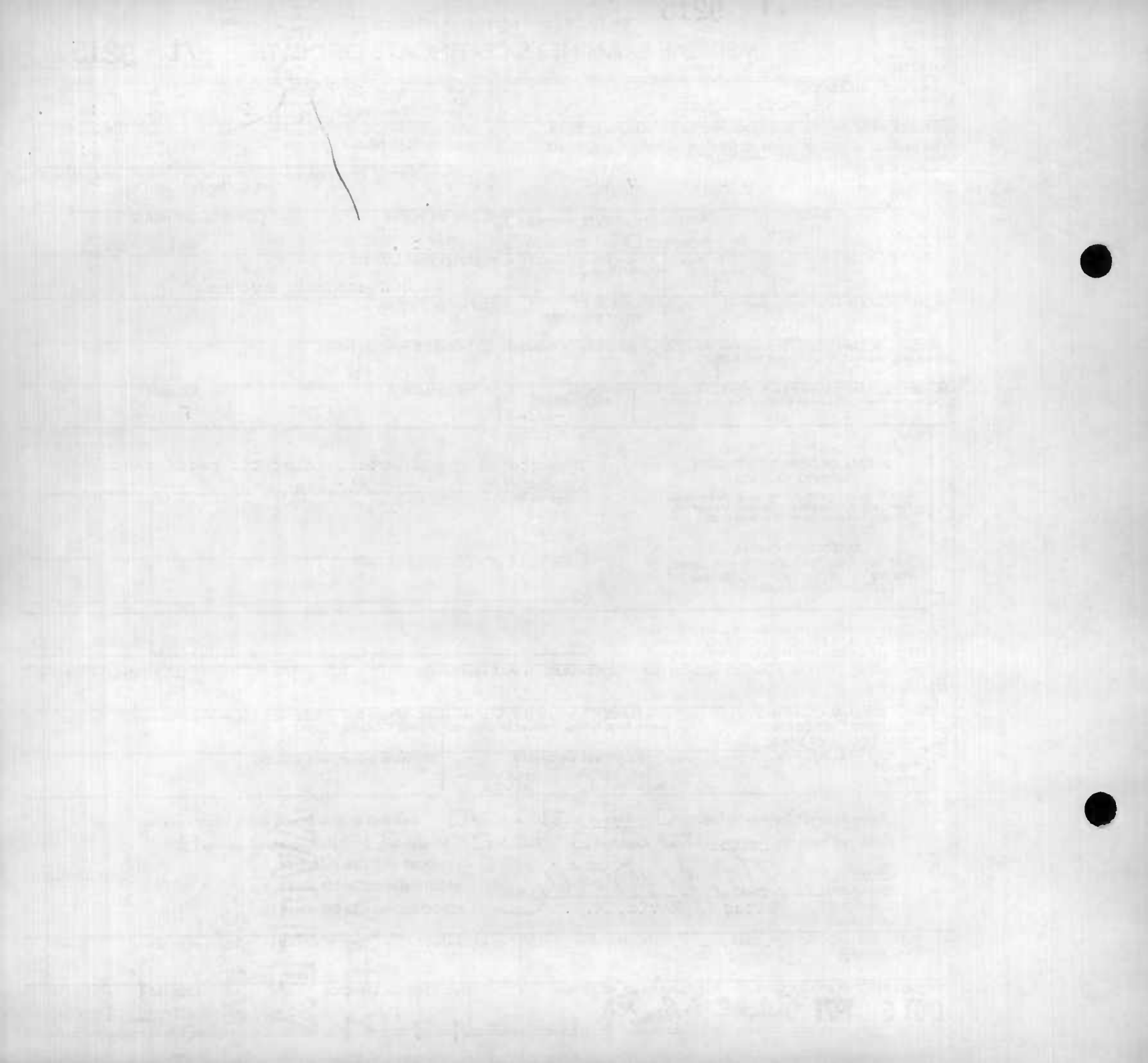


BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9215

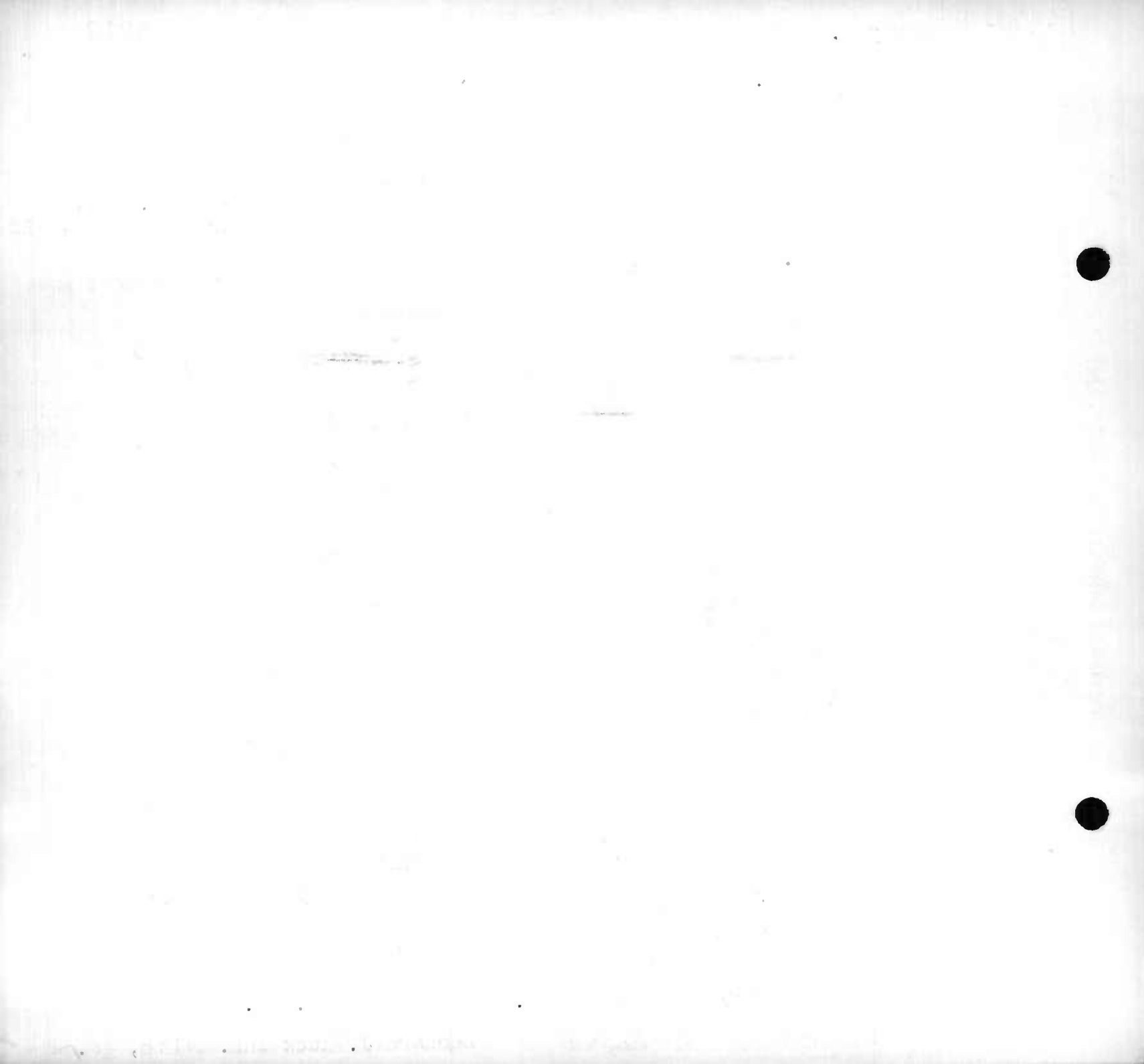
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Ulysses Fisher</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>9</b> Day <b>30</b> Year <b>71</b> Hour <b>4:18</b> p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 1422 Chesapeake Avenue</b>		3. DATE PRONOUNCED DEAD Month <b>9</b> Day <b>30</b> Year <b>71</b> Hour <b>4:18</b> p.m.	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) <b>85</b>		E. STREET AND NUMBER <b>1422 Chesapeake Avenue</b>	
11. BIRTHPLACE (State or foreign country) <b>Eastern Shore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unknown</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>	
15. MOTHER'S MAIDEN NAME <b>Unknown</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. <b>220-10-8424</b>		18. INFORMANT <b>Mrs Margaret Fisher, 1109 Orlean</b>	
19. <b>412-21</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Hypertension and arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) Month ( ) Day ( ) Year ( ) Hour ( )		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10/1/71</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>10/4/71</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>St. Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>A Halstead</b>		ADDRESS <b>1206 W north Ave</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

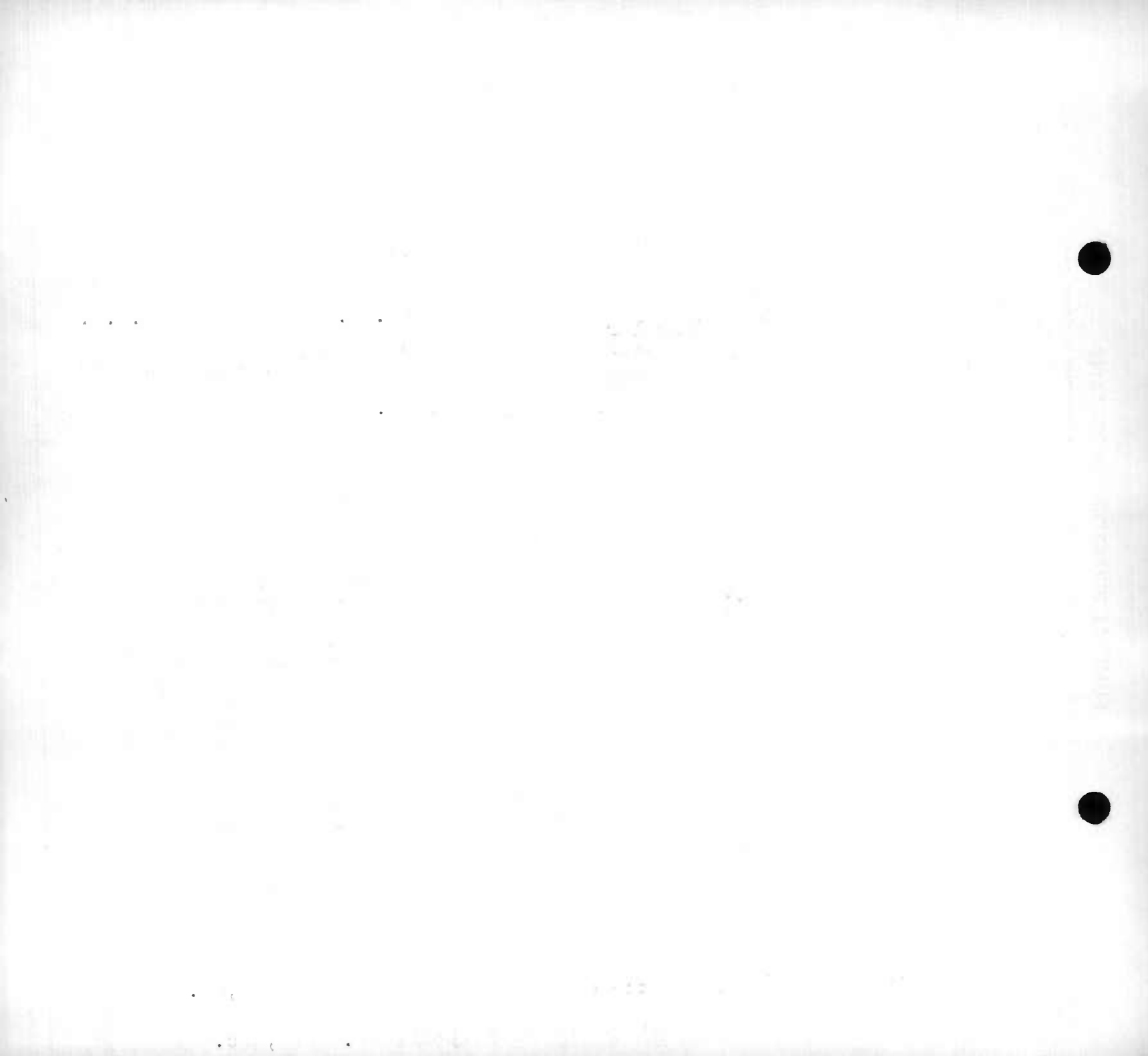
Harvey L. Phillips 9216		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9216	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Harvey L. Phillips		2. DATE AND HOUR OF DEATH Sept. 29, 1971 12:15 AM			
3. PLACE IN BALTIMORE (MARYLAND, WHERE PRONOUNCED DEAD)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 906			
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hosp. of Maryland		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouseman		8. DATE OF BIRTH 01-03-03		9. AGE (In years last birthday) 68	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Everett Phillips		14. MOTHER'S MAIDEN NAME Florence ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 316 64454		17. INFORMANT Elizabeth Fannon 9708 Overdale Ave 21231	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia generalized ar-sclerosis Chronic Brain Syndrome ASHD. Pul. TBC		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9/28/71	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 28 19 71 to Sept. 29 19 71 that (I) (we) last saw the deceased alive on Sept. 29 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Kim, M.D.				23B. DATE SIGNED Sept. 29/71	
23C. PHYSICIAN'S NAME (Type) JONAS SOOK, KIM, M.D.				23D. ADDRESS Lutheran Hosp. of Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/4/71		24C. NAME OF CEMETERY or CREMATORY Moreland Mem.	
24D. LOCATION Balto. Md.		24E. NAME OF REGISTRAR Leonard J. Buck		24F. FUNERAL DIRECTOR Buck Inc. Balto., Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
U-330 71 9217		CERTIFICATE OF DEATH		71 9217	
1. NAME OF DECEASED (Type or Print) <b>MRS CAROLYN WHITEHEAD</b>		2. DATE AND HOUR OF DEATH <b>10-2-71 11 35 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME &amp; Hospital</b>		A. STATE <b>MARYLAND</b>		B. COUNTY <b>21206 2641</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>4307 ARIZONA AVE</b>			
5. SEX <b>Female</b>	6. RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-28-96</b>	9. AGE (In years last birthday) <b>80</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
13. FATHER'S NAME <b>BENJAMIN KLINGLER</b>		14. MOTHER'S MAIDEN NAME <b>Georgianna Funk</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes/no) or unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-40-0113</b>		17. INFORMANT <b>Edward G. Whitehead</b>	
				ADDRESS <b>Same as above</b>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <b>CARDIO RESPIRATORY ARREST. 10 min</b>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Severe hepatic insufficiency 8 days</b>		
			(C) DUE TO, OR AS A CONSEQUENCE OF: <b>Centros of the Liver Hyper splenic. one yr</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<b>ANASARCA</b>		
			<b>congestive heart FAILURE. 1 year</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-27-71</b> 19 <b>71</b> to <b>10-2-</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>10-2</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ma. Elena V. Mangay</b>				23B. DATE SIGNED <b>10-3-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>MA. ELENA V. MANGAY</b>				23D. ADDRESS <b>100 N. Broadway, Bkts - m 2123</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/6/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1971</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.</b>			
25D. ADDRESS					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <span style="font-size: 1.5em;">71</span> <span style="font-size: 1.5em;">9218</span>	
<div style="display: flex; justify-content: space-between;"> <span>William J. Kunkel</span> <span>9218</span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print) <b>KUNKEL WILLIAM J.</b>		2. DATE AND HOUR OF DEATH <b>10-3-71 5:30 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Md.</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital of Maryland</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		E. STREET AND NUMBER <b>2200, Mosby Avenue, Balto MD-21207</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2-18-01</b>	9. AGE (in years last birthday) <b>70 yrs</b>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John A.F. Kunkel</b>			14. MOTHER'S MAIDEN NAME <b>Anna M. Vaeth</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>no</b>		16. SOCIAL SECURITY NO. <b>218-66-1552</b>		17. INFORMANT ADDRESS <b>Mrs. Theresa Thim 105 Riverside Dr</b>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Acidosis</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (b) <b>Chr. obstructive Pulmonary Disease</b> (c) <b>Chronic Obstructive Pulmonary Disease</b>				5 yrs <b>5 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>10-1-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>10-1-71</b> to <b>10-3-71</b> that (1) (we) last saw the deceased alive on <b>10-3-71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Samuel</b>				23B. DATE SIGNED <b>10-3-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>JASON SAMUEL</b>				23D. ADDRESS <b>Lutheran Hospital of Maryland 730, Ashburton Street, Baltimore MD 21206</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/3/71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1971</b>			
25B. NAME OF REGISTRAR <b>Valerie E. Taylor, R.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		25D. ADDRESS <b>Balto. 5305 Harford</b>	



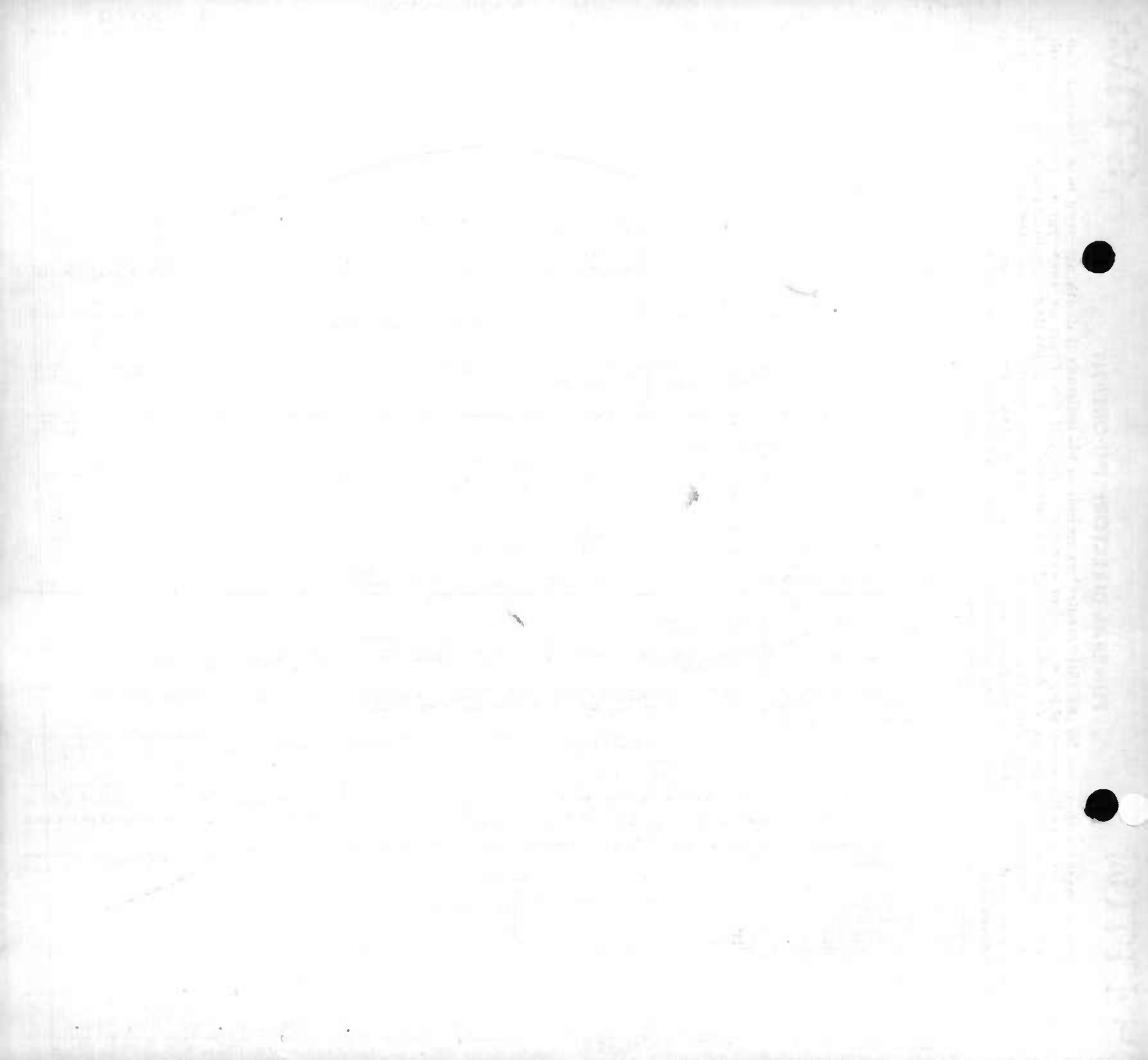
# FUNERAL DIRECTOR: IMPORTANT

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## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **71 9219**

<b>P-252 71 9219</b> BIRTH NO. <b>71 9219</b> 1. NAME OF DECEASED (Type or Print) <b>THOMAS A. PESNICK</b>		2. DATE AND HOUR OF DEATH <b>10-3-71 13-450</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 Union M. Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD</b> B. COUNTY <b>5436 Sarril Rd. - 2 Apt A. Balto. Md.</b> C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5436 Sarril Rd. Apt A</b>	
5. SEX <b>M</b> 6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 5-1908</b> 9. AGE (In years last birthday) <b>63</b>	10. Under 1 Yr. Months: Days: Hours: Min. 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Eskay Co. Personnel</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b> 11. BIRTHPLACE (State or foreign country) <b>Phila. Pa.</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNK</b>		14. MOTHER'S MAIDEN NAME <b>UNK</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. 17. INFORMANT <b>Mrs Ethel Pesnick Same Above</b> ADDRESS	
18. <b>410.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute myocardial infarction</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <b>Acute myocardial infarction</b> (B) DUE TO, OR AS A CONSEQUENCE OF <b>Unst. M. Hosp. 9-9-71 to 10-2-71</b> (C) <b>Hypertens. U.D. - approx MI (1959)</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/9</b> <b>1971</b> to <b>10-2-71</b> <b>1971</b> that (I) (we) last saw the deceased alive on <b>10-2-71</b> <b>1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Bernard J. Cohen M.D.</b>		23B. DATE SIGNED <b>10/3/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Bernard J. Cohen</b>		23D. ADDRESS <b>Union Memorial Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10 6 71</b>	
24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1971</b>		25B. NAME OF REGISTRAR <b>Leonard J. Ruck</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto, Md.</b>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

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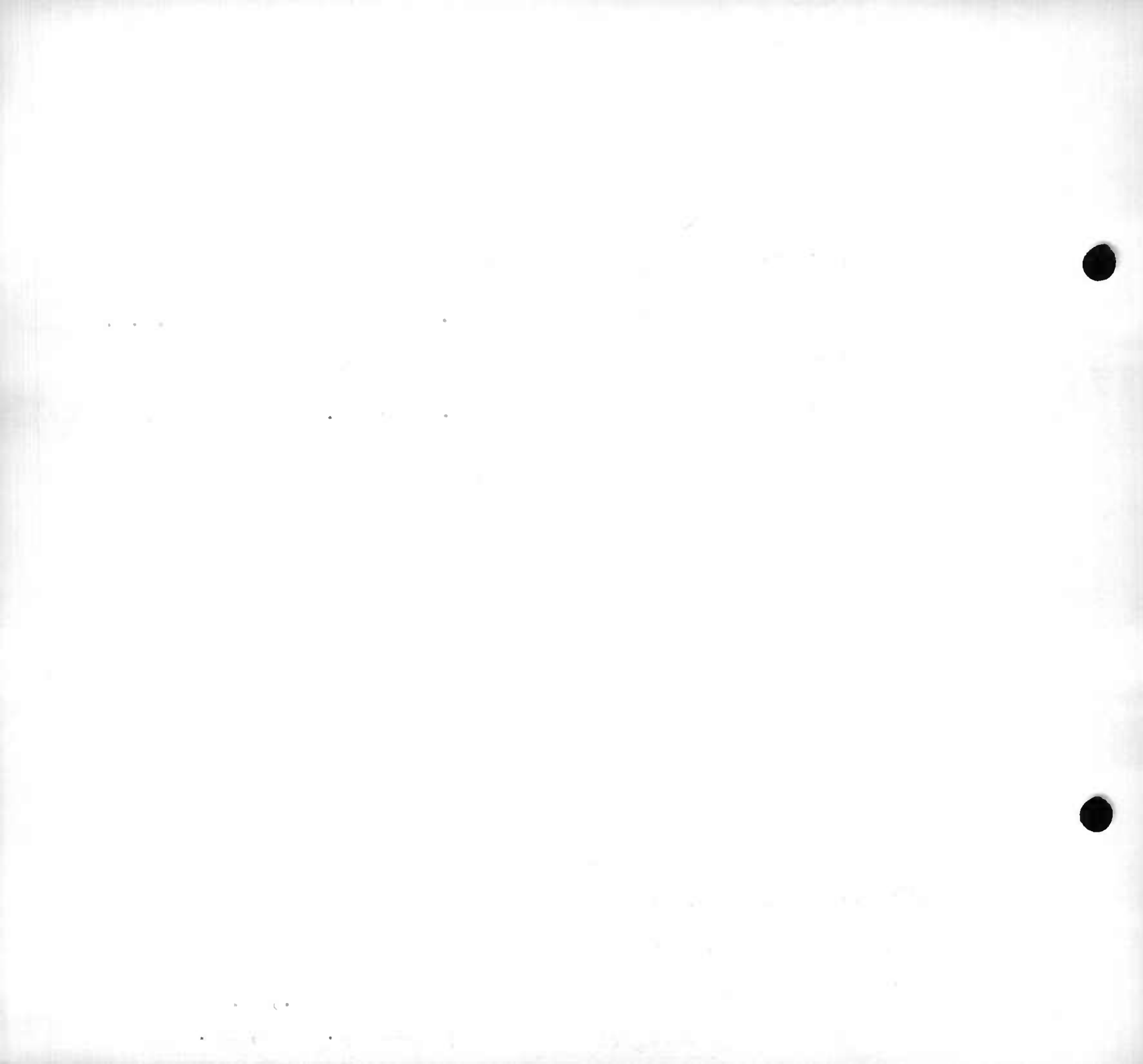
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9220</span>	
BIRTH NO. <span style="font-size: 1.5em;">B-530 71 9220</span>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">ANTHONY (Antonio) BONAIUTO</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">Oct. 2, 1971 11.35 p. M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.5em;">00 2220 LOUISE AVENUE</span>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">2706</span>		
			C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">2220 Louise Ave.</span>		
5. SEX <span style="font-size: 1.2em;">male</span>	6. RACE <span style="font-size: 1.2em;">caucasian</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">Jan. 30, 1887</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">84</span>	10. Under 1 Tr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">custom tailor: retired</span>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">SICILY</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">Italy</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">Santo Bonaiuto</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Giovanna Campeillio</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">216-07-0439</span>			17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mrs. Jean Mitchell same</span>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last			CAUSE OF DEATH <span style="font-size: 1.5em;">Bronchogenic Carcinoma</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">1 year ±</span>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">April 29, 1971</span> to <span style="font-size: 1.2em;">Oct 2, 1971</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">April 29, 1971</span> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Ramon Roig Jr.</span>			23B. DATE SIGNED <span style="font-size: 1.2em;">10. 4 71</span>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Dr. Ramon F. Roig, Jr.</span>			23D. ADDRESS <span style="font-size: 1.2em;">St. Joseph Professional Building, Balto, Md.</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">10/4/71</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Holy Redeemer</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Balto. Md.</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">OCT 5 1971</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Leonard J. Ruck, Inc. - Balto, Md. - 14</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9221</u>
BIRTH NO. <u>R-300 71 9221</u>		1. NAME OF DECEASED (Type or Print) <u>MARY A. READ</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>OCTOBER 2, 1971</u> <u>3:43</u> P.M.		
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL HOSPITAL</u> <u>48</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u> <u>5300</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>2529 WYCLIFFE RD.</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 17, 1899</u>	9. AGE (in years last birthday) <u>72</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXX</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Seamstress</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>
13. FATHER'S NAME <u>Andrew Miller</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-10-2843</u>		17. INFORMANT <u>Mrs. Merle C. Bowers</u>
18. <u>486X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>10-3-71</u> to <u>10-2-71</u> that (I) (we) last saw the deceased alive on <u>10-2-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Michael Grasso M.D.</u>		23B. DATE SIGNED <u>10-3-71</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>MICHAEL GRASSO M.D.</u>		23D. ADDRESS <u>Maryland General Hosp.</u>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/6/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>
24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 5 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Fabel, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc.</u>		





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 9222	
CERTIFICATE OF DEATH				REG. NO.	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Oliver W. Dellinger</span>				<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">10/3/1971</span> <span style="font-size: 1.2em;">8:55 A.</span>	
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">42 Sinai Hospital</span>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <span style="font-size: 1.2em;">Md</span> <b>B. COUNTY</b> <span style="font-size: 1.5em;">2717</span>	
<b>5. SEX</b> <span style="font-size: 1.2em;">m.</span> <b>6. RACE</b> <span style="font-size: 1.2em;">W.</span> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>				<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">3/30/1892</span> <b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">79</span>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Ret. Railroader</span>				<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Pa.</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">John Dellinger</span>				<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">-</span>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>				<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">716-12-3636</span>	
<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mrs. Kay Barton</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">414 Park St. York Pa.</span>					
<b>18. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.                 </div> <div style="width: 50%;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <span style="font-size: 1.5em;">Probable acute myocardial infarction</span> <span style="font-size: 1.5em;">2 hrs.</span>  <b>(A) IMMEDIATE CAUSE</b>                      DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.5em;">Diabetes Mellitus</span> <span style="font-size: 1.5em;">5 yrs.</span>  <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b>  <span style="font-size: 1.5em;">Severe Rheumatoid Arthritis</span> <span style="font-size: 1.5em;">10 yrs.</span>  <b>(C)</b> </div> </div>					
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (1) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">Feb 6</span> <span style="font-size: 1.2em;">1970</span> <b>to</b> <span style="font-size: 1.2em;">Oct 3</span> <span style="font-size: 1.2em;">1971</span> <b>that (1) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">Oct 1</span> <span style="font-size: 1.2em;">1971</span> <b>and that (n) (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Alan B. Cohen</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.5em;">Oct 4, 1971</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Alan B. Cohen MD</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">Marylander Apts. Balto., Md.</span>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">10/5/71</span>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Greenmount Cem.</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">York, Pa.</span>					
<b>25A. DATE RECD BY HEALTH DEPT.</b> <span style="font-size: 1.5em;">OCT 5 1971</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Talley, M.D.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Leonard J. Ruck Inc. Balto. Md.</span>	

No Previous Address

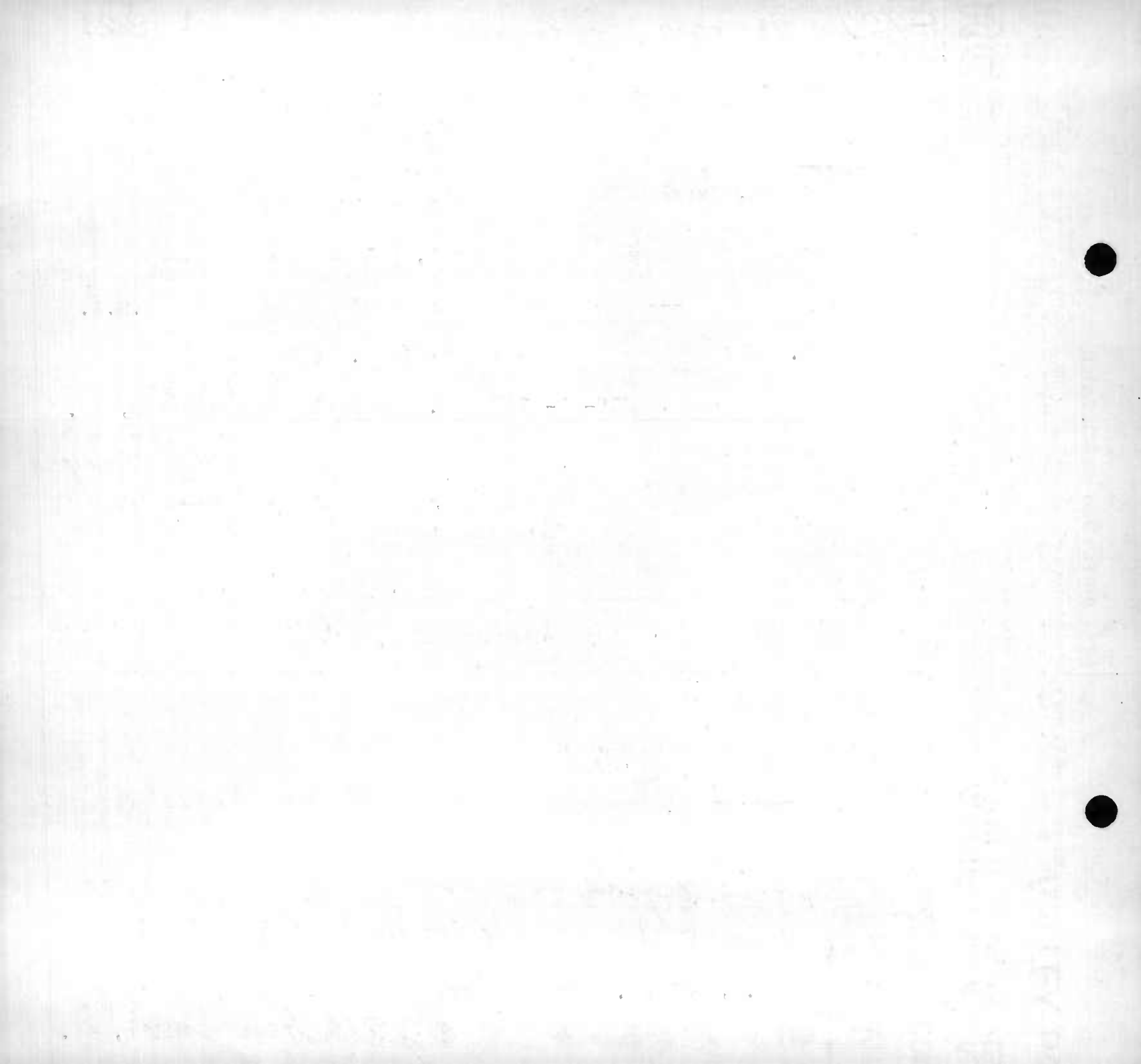
listed with N.H.

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# FUNERAL DIRECTOR: IMPORTANT

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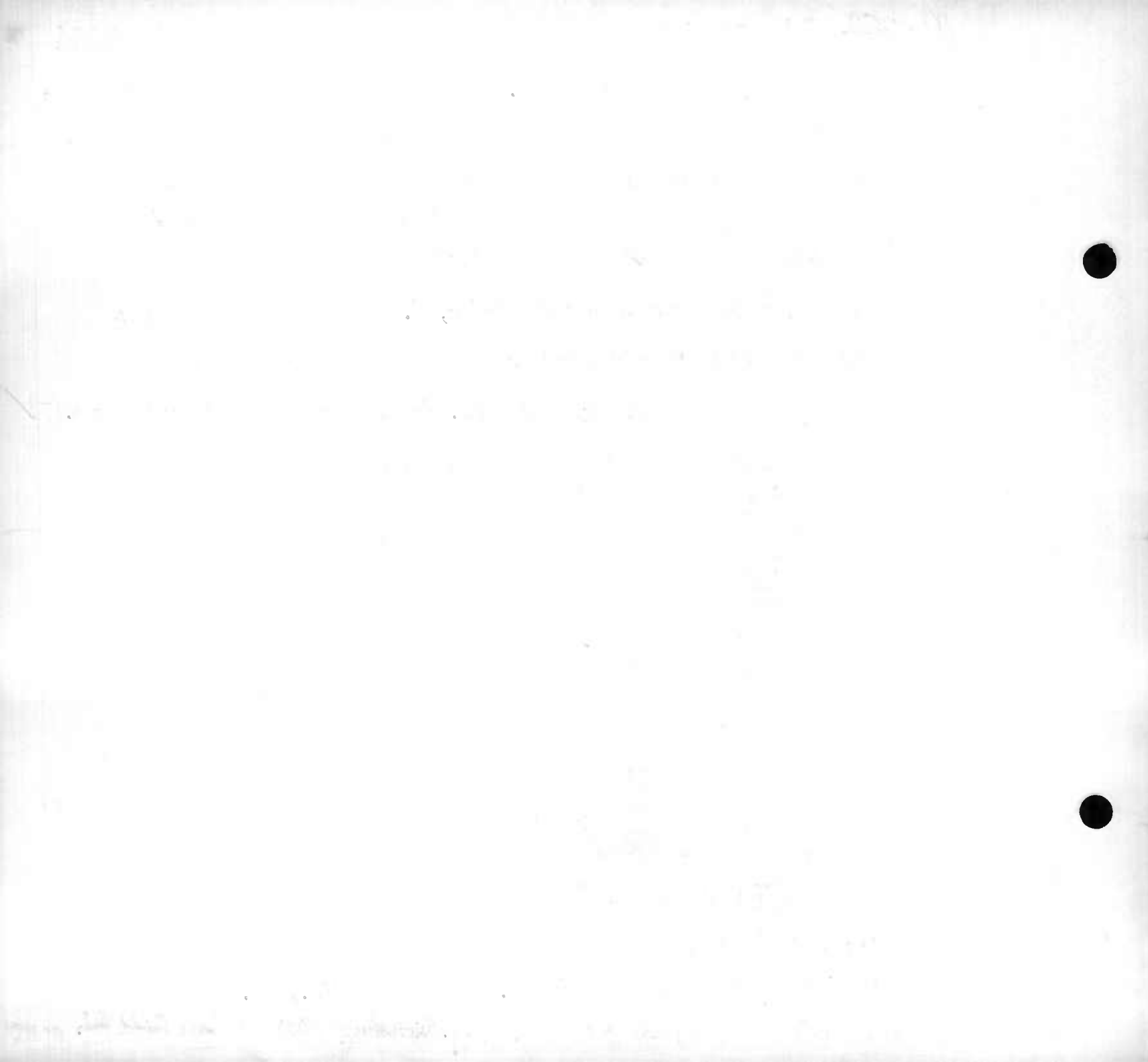
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9223</span>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Bertha Maye Volz</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">October 1, 1971</span> <span style="float: right;">9 p. M.</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">90 Edgewood Nursing Home Baltimore, Maryland</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">2748</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore 12</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">5920 Falkirk Road</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">White</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">May 1, 1891</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">80</span>	<b>If Under 1 Yr.</b> Months Days <b>If Under 24 Hrs.</b> Hours Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">---</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>		<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">William I. Wolf</span>			
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Annie F. Falk</span>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>			
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">219-03-5285</span>		<b>17. INFORMANT</b> <span style="float: right;"><b>ADDRESS</b></span> <span style="font-size: 1.2em;">Mrs. Ann Seal</span> <span style="float: right;"><span style="font-size: 1.2em;">35 Kingsley Road Owings Mills, Md.</span></span>			
<b>18. CAUSE OF DEATH</b>					
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.5em;">Myocardial Infarction 15 days</span> <span style="font-size: 1.5em;">Advanced Arteriosclerotic Heart Disease 12 years</span> <span style="font-size: 1.5em;">Chronic obstructive Lung Disease 6 years</span>			
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>		<span style="font-size: 1.5em;">Cerebrovascular Apoplexy</span>			
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">4/10/91</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (<del>the hospital</del>) attended the deceased from <span style="font-size: 1.2em;">8/12</span> 19 <span style="font-size: 1.2em;">48</span> to <span style="font-size: 1.2em;">10/1</span> 19 <span style="font-size: 1.2em;">71</span>, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">19</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">John H. Hirschfeld M.D.</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">10/2/71</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">John Hirschfeld</span>		<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">6919 Harford Rd, Balto. Md.</span>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">Oct. 4, 1971</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Mt. Olivet Cemetery</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">OCT 5 1971</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">[Signature]</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="float: right;"><b>ADDRESS</b></span> <span style="font-size: 1.2em;">[Signature]</span> <span style="float: right;"><span style="font-size: 1.2em;">Owings Mills, Md.</span></span>			

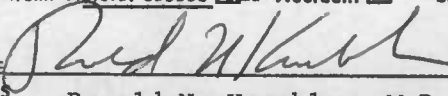


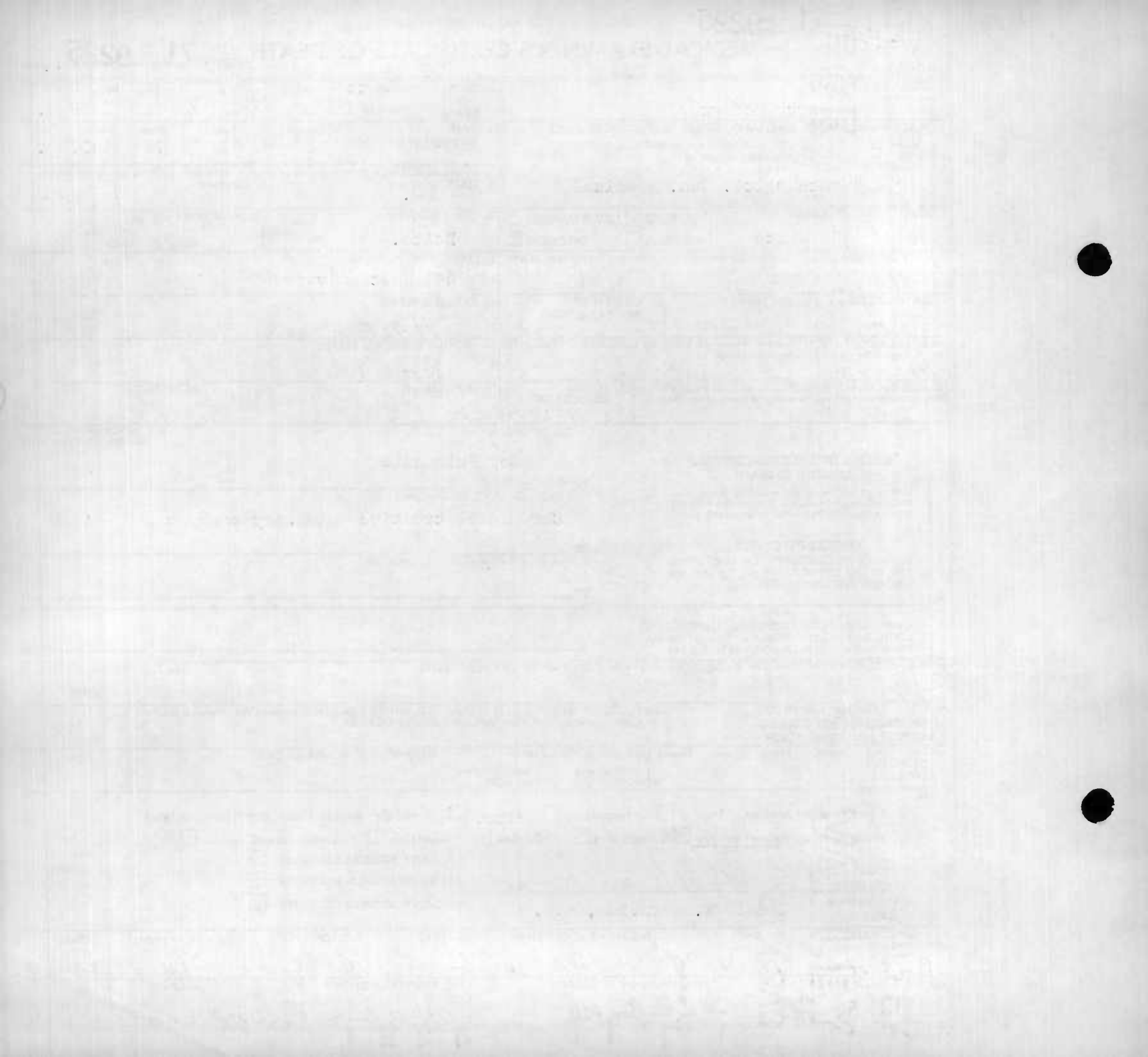
# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9224</u>	
M-252 71 9224		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>McKENZIE, MELBA M.</u>		2. DATE AND HOUR OF DEATH <u>10/2/71</u> <u>10:10 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2802</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL of BALTIMORE</u> <u>42</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>CAU</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK, BALTO. CITY DEPT. OF PHS. &amp; D.</u>		8. DATE OF BIRTH <u>7/7/14</u>		9. AGE (In years last birthday) <u>57</u>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto, Md. USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ADA M. HEARN</u>		14. MOTHER'S MAIDEN NAME <u>ADA M. HEARN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>216 05 9842</u>		17. INFORMANT ADDRESS <u>Mrs. Ada M. Hearn 3211 Drightwood ave. (7)</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Severe Blood Poisoning</u> <u>BLEEDING Esophageal Varices</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) <u>Liver Cirrhosis</u>		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2/2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/29</u> 19 <u>71</u> to <u>10 2</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>70 - 2</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Amelito J. Ordinarona Jr. M.D.</u>				23B. DATE SIGNED <u>10-2-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>AMALITO J. ORDINARONA - M.D.</u>		23D. ADDRESS <u>SINAI Hosp. of BALTO.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/5/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	
24D. LOCATION <u>Balto., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 5 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>J. J. Stansbury</u>		25D. ADDRESS <u>6411 Windsor Mill Rd. 21207</u>	



BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 71 9225			
BIRTH NO.											
1. NAME OF DECEASED (Type or Print) Harry McCarthy						2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 1 Year 71 Hour 1:37 p.m.					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Balto. Gen. Hospital						3. DATE PRONOUNCED DEAD Month 10 Day 1 Year 71 Hour 1:37 p.m.					
6. SEX male						7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution; residence before admission) A. STATE Md. B. COUNTY 1702	
9. DATE OF BIRTH 2-9-12						10. AGE (In years last birthday) 59		11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic						14B. KIND OF BUSINESS OR INDUSTRY Diesel		13. FATHER'S NAME JAMES			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.II						17. SOCIAL SECURITY NO. 194-07-1989		15. MOTHER'S MAIDEN NAME RAYB			
19. CAUSE OF DEATH						18. INFORMANT WIFE		ADDRESS SAME			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.						Cor Pulmonale (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic obstructive pulmonary emphysema (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2						20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.)						22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE  M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 10/1/71 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>											
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 10-4-71		24C. NAME of CEMETERY or CREMATORY Cedar Hill		24D. LOCATION (City, town, or county) (State) Ritchie Hwy BALTO. MD			
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1971				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Hahn Funeral Home					





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

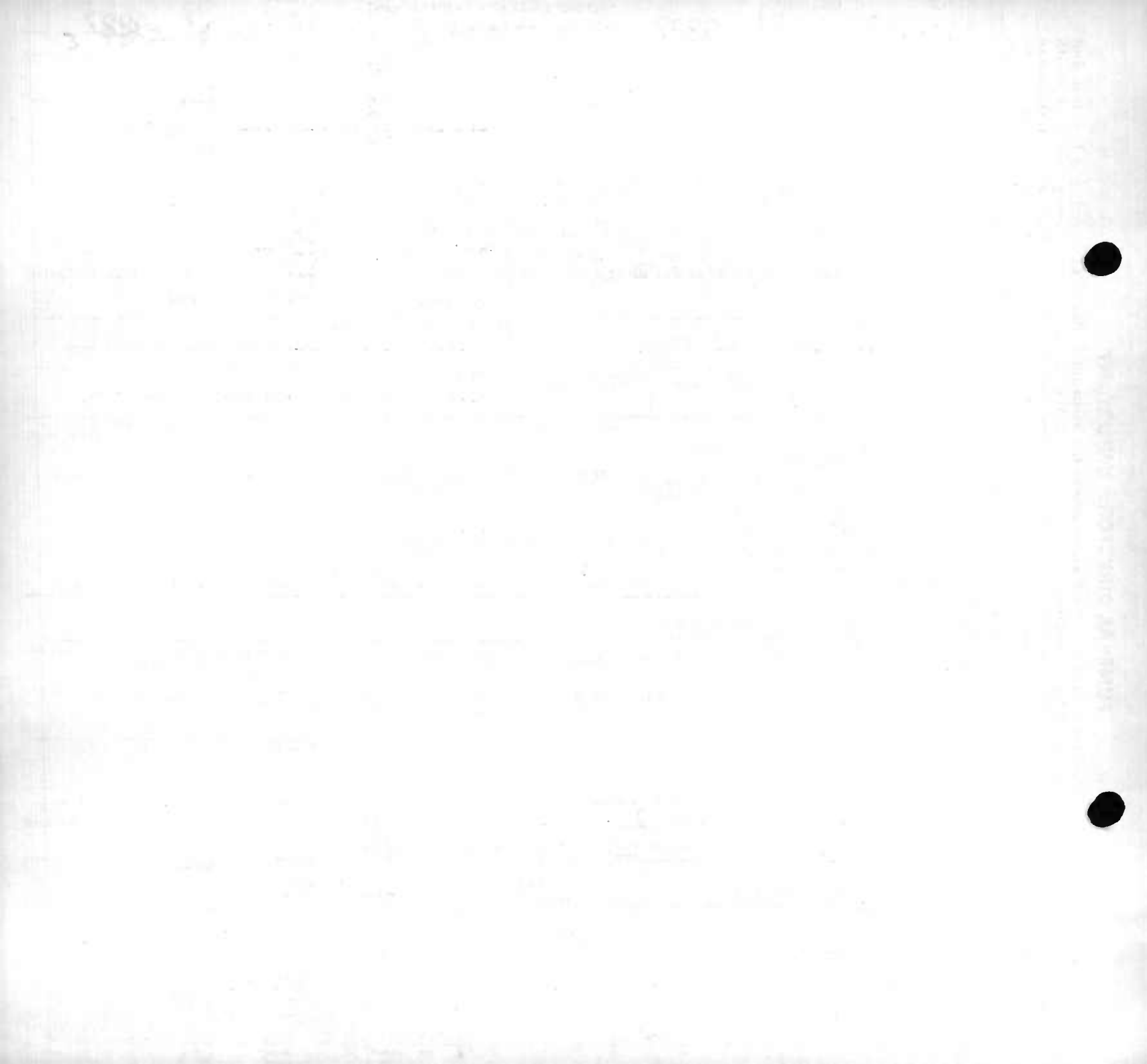
M-460 71 9226				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9226	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Bertha P. Mueller</i>				2. DATE AND HOUR OF DEATH <i>Oct - 1 - 71 9:00 PM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Long Green Nursing Home</i>				4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE <i>Md</i> B. COUNTY <i>2749</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Melrose Ave Baltimore</i>				C. CITY OR TOWN <i>Balto</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i> 6. RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>August 1893</i>		9. AGE (in years last birthday) <i>78</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>NO</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>Julius Cross</i>			
14. MOTHER'S MAIDEN NAME <i>Bertha Koch</i>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			
16. SOCIAL SECURITY NO.				17. INFORMANT <i>Betty Keeney</i> ADDRESS <i>5 Solihale Ct</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <i>Pneumonia Bilat</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 wk.</i>	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>arteriosclerotic Cardiovascular Disease</i>				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>with Cerebral anoxia &amp; Semility.</i>		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 30 1971</i> to <i>Oct 1 1971</i> that (I) (we) last saw the deceased alive on <i>Sept 30 1971</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>David W. Kasik Jr.</i>				23B. DATE SIGNED <i>10/2/71</i>			
23C. PHYSICIAN'S NAME (Type) <i>Dr. Kasik Jr. M.D.</i>				23D. ADDRESS <i>9005 Harford Rd</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/5/71</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 5 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, R.D.</i>		25C. FUNERAL DIRECTOR <i>C. F. EVANS &amp; SON</i>		ADDRESS <i>8802 Harford road</i>	

Adm '69.  
1931 Northbourne Rd.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

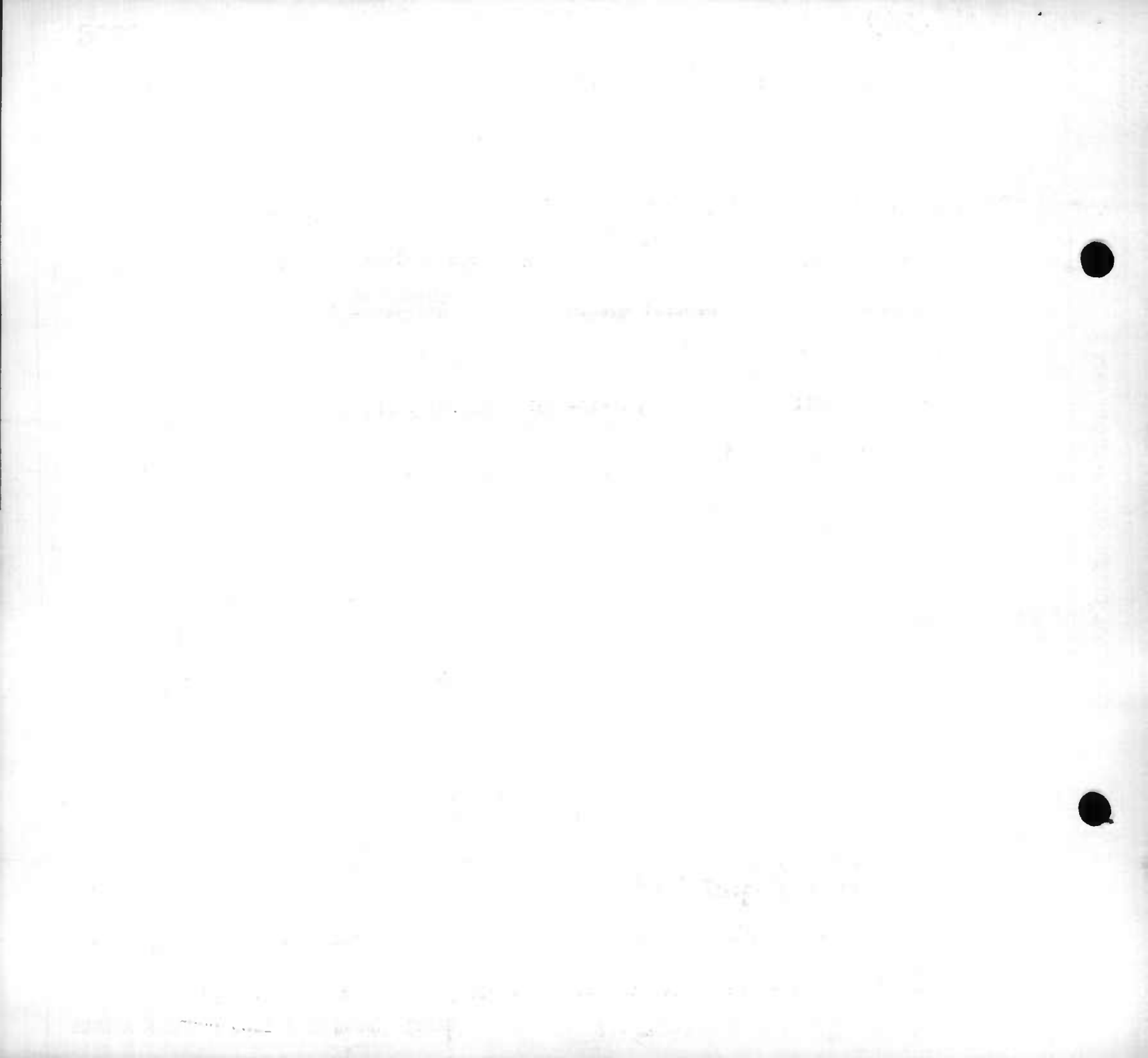
BIRTH NO. <span style="float: right;">71 9227</span>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">71 9227</span>	
1. NAME OF DECEASED (Type or Print) <b>AUGUST KRABBE</b>				2. DATE AND HOUR OF DEATH <b>9-30-71 9:15 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3902 Southern Ave.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/25/1896</b>	9. AGE (in years last birthday) <b>74 75</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN Henry Krabbe</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN Catherine Schwerman</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Genvieve E. Smith 6101 Loch Raven Blvd.</b>			
18. <b>71271</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>Cerebrovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF:			
				(B) <b>ASCUD-</b> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <b>Dehydration. No Brain autolysis</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>9-29-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9-29-71</b> 19 to <b>9-30-71</b> 19 that (I) (we) last saw the deceased alive on <b>9-30-71</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Eugenia K. Seitz</b>				23B. DATE SIGNED <b>9-30-71</b>		23C. PHYSICIAN'S NAME (Type) <b>JAIRO RANIREZ MD</b>	
23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>		23E. DEGREE					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>10/2/71</b>		<b>Loudon Park Cemetery</b>		<b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Seitz</b>		25C. FUNERAL DIRECTOR <b>Eugenia K. Seitz</b> ADDRESS <b>Seitz Funeral Home 5209 York Rd. 21212</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

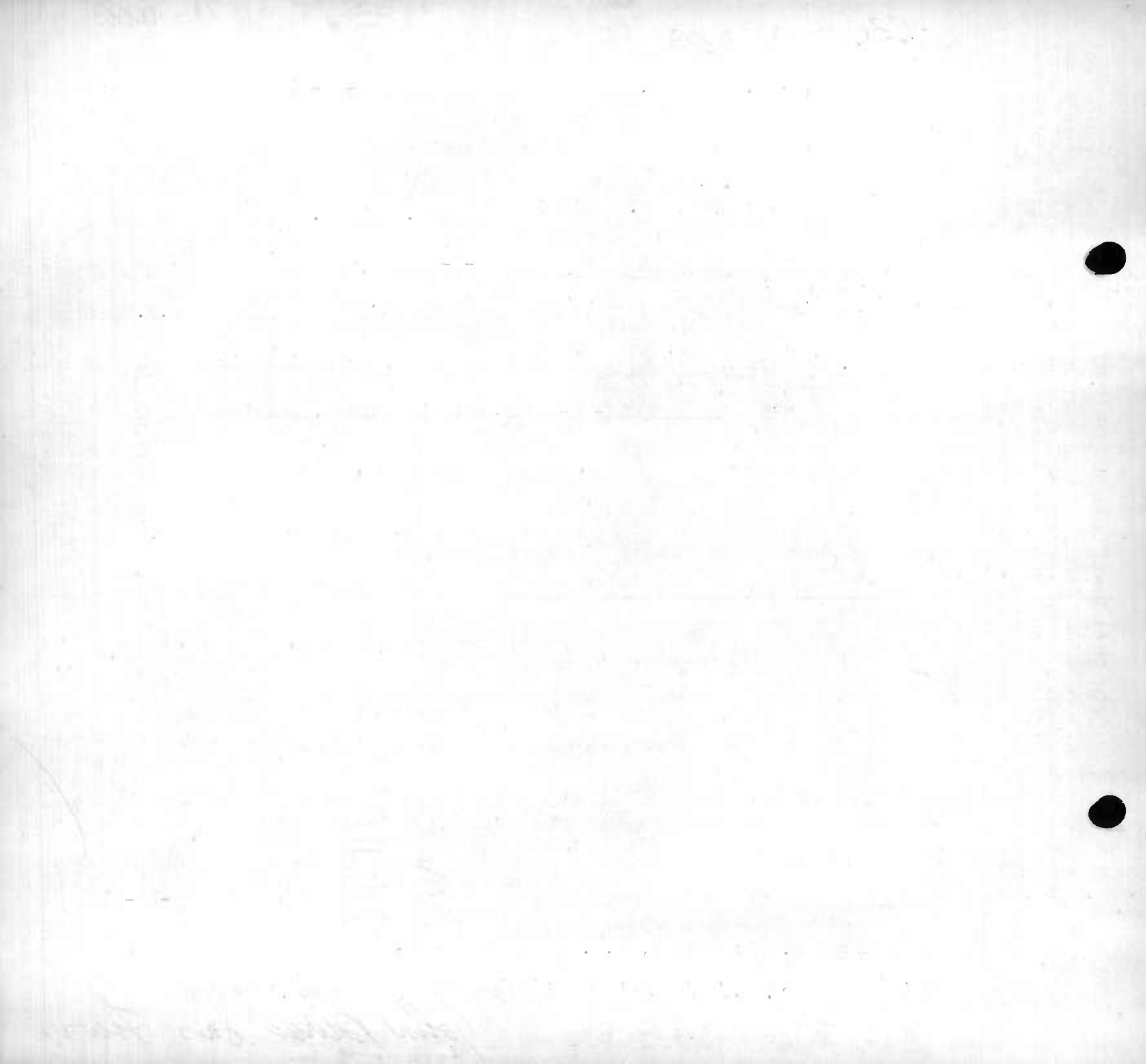
R-240 BIRTH NO.		71 9228		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 9228	
1. NAME OF DECEASED (Type or Print) <u>Rockwell Robert E.</u>				2. DATE AND HOUR OF DEATH <u>10-1-71</u> <u>10: A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY of Maryland Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2646</u>			
				C. CITY OR TOWN <u>BAITO.</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1305 DUNDALK AVE.</u>			
5. SEX <u>M.</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Sept 29-1922</u>	9. AGE (In years last birthday) <u>49</u>	If Under 1 Yr. Months	If Under 24 Hrs. Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>General Motors</u>		11. BIRTHPLACE (State or foreign country) <u>Ashland Pa.</u> <del>XXXXXXXXXX</del>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Rockwell</u>				14. MOTHER'S MAIDEN NAME <u>1 ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>043-18-9287</u>		17. INFORMANT <u>Mrs. Mary Fields</u>		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUCINOMA of left lung</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>9-23-71</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CAUCINOMA of left lung</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
MEDICAL CERTIFICATION							
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9-23</u> 19 <u>71</u> to <u>10-1</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10-1</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Joe V. Iglesias M.D.</u>				23B. DATE SIGNED <u>10-1-71</u>			
23C. PHYSICIAN'S NAME (Type) <u>JOSE V. IGLESIAS M.D.</u>				23D. ADDRESS <u>University of Maryland Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-4-71</u>		24C. NAME of CEMETERY or CREMATORY <u>St Stanislaus Cemetery</u>		24D. LOCATION City, town, or county <u>Baltimore, Maryland</u> State <u></u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>WALTER DABROWSKI</u>		ADDRESS <u>1005 DUNDALK AVENUE</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
S-530 71 9229		71 9229			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SMITH, MRS. EDITH B.		9-30-71 8:30 AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 91 KESWICK		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 700 W. 40th Street Baltimore, Md. 21211		MARYLAND C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 622 W. 40th St.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
F	W		8-3-83	88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Cashier - retired		College Office		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John T. Henderson		Frances Sinclair		U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		216-05-2172 Medical Records, Keswick	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Thrombosis		Instant	
		(B) Arteriosclerotic Cardiovascular Disease		1 1/2 yrs	
		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 21 Apr 1971 to 30 Sept 1971, that (I) (we) lost saw the deceased alive on 30 Sept 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Aubrey D. Richardson, M.D.				23B. DATE SIGNED 9-30-71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Aubrey D. Richardson, M.D.				700 W. 40th Street	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		Oct. 2, 1971		Prospect Hill Cemetery	
				Towson, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 5 1971		John E. Jones, M.D.		John E. Jones, M.D.	

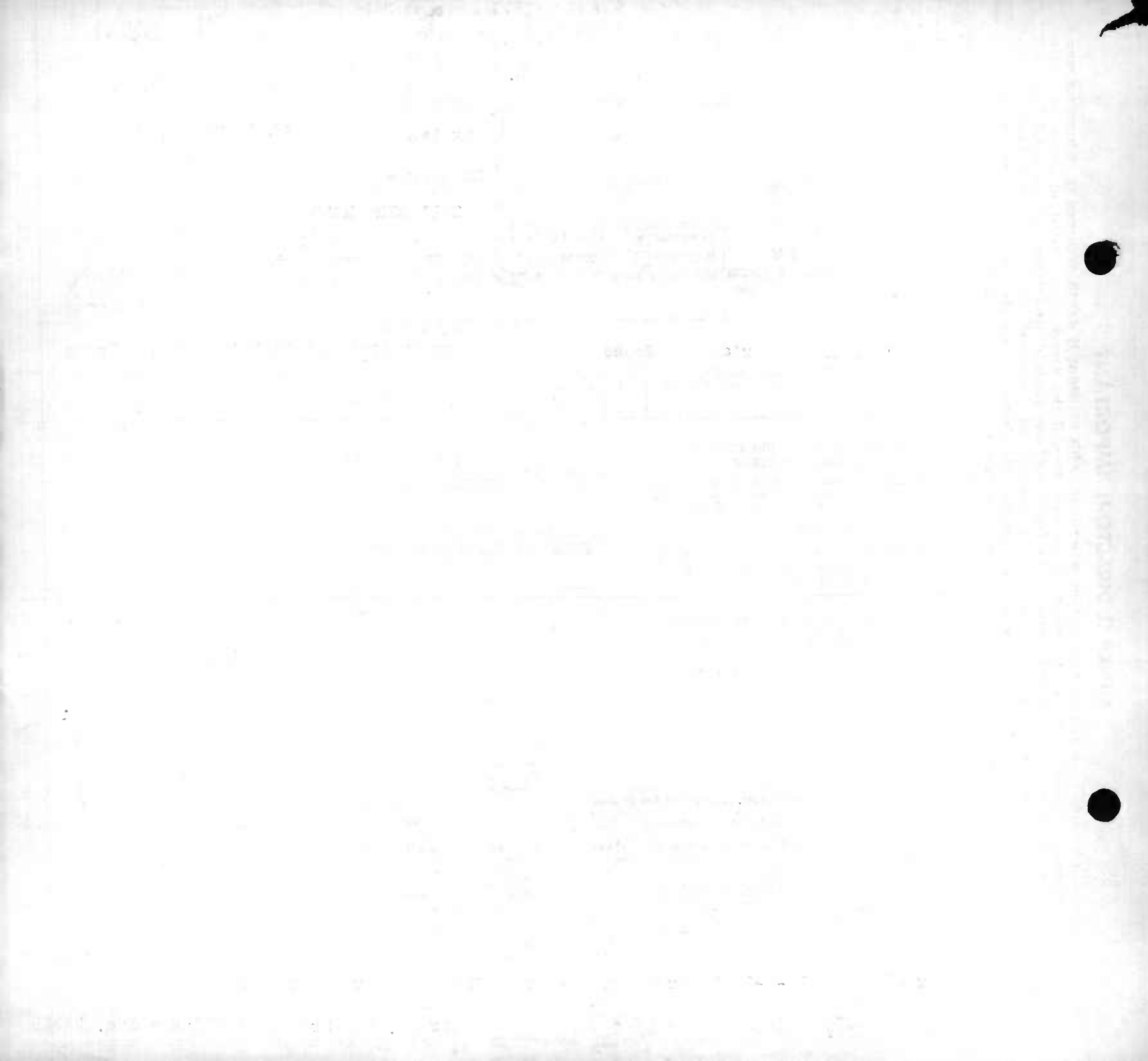




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9230</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">J-520 71 9230</span>		<b>CERTIFICATE OF DEATH</b>			
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Jones, James L.</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">9/29-71 - 12 PM</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">43 So. Balto. Gen Hosp.</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Lansdowne</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">2911 BERO ROAD, HANOVER ST.</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">M</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">W</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">10-20-99</span>	<b>9. AGE</b> (in years last birthday) <span style="font-size: 1.2em;">71</span>	<b>If Under 1 Yr.</b> Months _____ <b>If Under 24 Hrs.</b> Days _____ Hours _____ Min. _____
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired</span>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> 		
<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Md.</span>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>		
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Uriah Jones</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Edith Young</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">Unknown</span>			<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">214-07-2790A</span>		
<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Keturah 2911 Bero Rd, Balto</span>			<b>ADDRESS</b> 		
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center;">II</div> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <span style="font-size: 1.2em;">Severe generalized atherosclerotic-vascular dis.</span>			<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">7-10 d.</span>		
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">9-27-71</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">Atherosclerosis</span>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <span style="font-size: 1.2em;">None</span>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">9/29-71</span> <b>19</b> <span style="font-size: 1.2em;">71</span> <b>to</b> <span style="font-size: 1.2em;">9/29</span> <b>19</b> <span style="font-size: 1.2em;">71</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">9/29</span> <b>19</b> <span style="font-size: 1.2em;">71</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Richard Siahaan</span>			<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">9/29-71</span>		<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">RICHARD SIAHAAN</span>
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">10-3-1971</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Frostburg Memorial Park</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Frostburg, Maryland</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">OCT 5 1971</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Fisher, M.D.</span>		<b>25C. FUNERAL DIRECTOR</b> <b>ADDRESS</b> <span style="font-size: 1.2em;">Howard H. Hubbard, 4107 Wilkens Ave. 21229</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-320 71 9231</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 9231</u>	
1. NAME OF DECEASED (Type or Print) <u>Theresa M. Matthews</u>				2. DATE AND HOUR OF DEATH <u>Oct 3, 1971</u> <u>5:20 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> <u>34</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Maryland</u>		B. COUNTY <u>1902</u>	
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3/09/13</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>House work</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Howard Knott</u>				14. MOTHER'S MAIDEN NAME <u>Dean</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-18-2713</u>		17. INFORMANT <u>Hospital Records</u>		ADDRESS	
18. <u>15331</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Adenocarcinoma of sigmoid colon, recurrent</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Adenocarcinoma of sigmoid colon</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Bronchopneumonia</u>						<u>days</u>	
19A. DATE OF OPERATION <u>7-20, 7-21, 7-29</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Proctectomy, Rectal biopsy, Sigmoidectomy</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7-16</u> 19 <u>71</u> to <u>10-3</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10-2</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Malcolm J. Yung</u>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <u>Malinke YUNYONGYING</u>				23D. ADDRESS <u>Bon Secours Hos Balto Md</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-6-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, Jr.</u>		25C. FUNERAL DIRECTOR <u>Thomas J. Kenny Inc</u>		ADDRESS <u>1600 Hollins St</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 9232	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. <b>R-526</b>		71 9232			
1. NAME OF DECEASED (Type or Print) <b>ADELAIDE RINEKER</b>		2. DATE AND HOUR OF DEATH <b>10-3-71</b> <b>1205 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>35 CHURCH HOME AND HOSPITAL</b> <b>BALTIMORE MD 21231</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>201</b>			
		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>2004 BANK STREET</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-21-915</b>	9. AGE (In years last birthday) <b>56</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>FREDERICK KLITZ</b>		14. MOTHER'S MAIDEN NAME <b>AGNES MILLER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-14-0316</b>		17. INFORMANT <b>Prabir K. Bose Church Home and Hospital</b>	
18. <b>1621 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CA Left Lung - spread to (L) Atrium -</b>  (B) DUE TO, OR AS A CONSEQUENCE OF: <b>METASTASES TO BRAIN</b>  (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>10-17-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CA (L) Lung</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-7-71</b> to <b>10-3-71</b> that (I) (we) last saw the deceased alive on <b>10-3-71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Prabir K. Bose</b>		23B. DATE SIGNED <b>10-3-71</b>			
23C. PHYSICIAN'S NAME (Type) <b>Prabir K. Bose MD</b>		23D. ADDRESS <b>Church Home &amp; Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-6-1971</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1971</b>		25B. NAME OF REGISTRAR <b>Prabir K. Bose</b>		25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc.</b>	
25D. ADDRESS <b>1901-07 Eastern Ave.</b>					



BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BEATRICE JONES

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

10

3

1971

7:09

P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

1001

6. SEX

female

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

1-15-24

10. AGE (in years  
lost birthday)

47

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1017 E. Preston St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Marshall Nutter

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Sarah J. Hayman

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Jesse Jones 1017 E. Preston Street

19.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

CAUSE OF DEATH

Gunshot wound of mouth with traumatic shock of

(A) IMMEDIATE CAUSE cervical spinal cord

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1017 E. Preston St.

22D. TIME  
OF INJURY  
(APPROX.)

10-3-71

7:01 p m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot by assailant.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10-4-71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10-8-71

24C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

24D. LOCATION (City, town, or county)

Anne Arundel Cty., Md.

25A. DATE REC'D BY HEALTH DEPT.

OCT 5

1971

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Wm C March

ADDRESS

928 E. North Ave.

2000

2000

2000





1

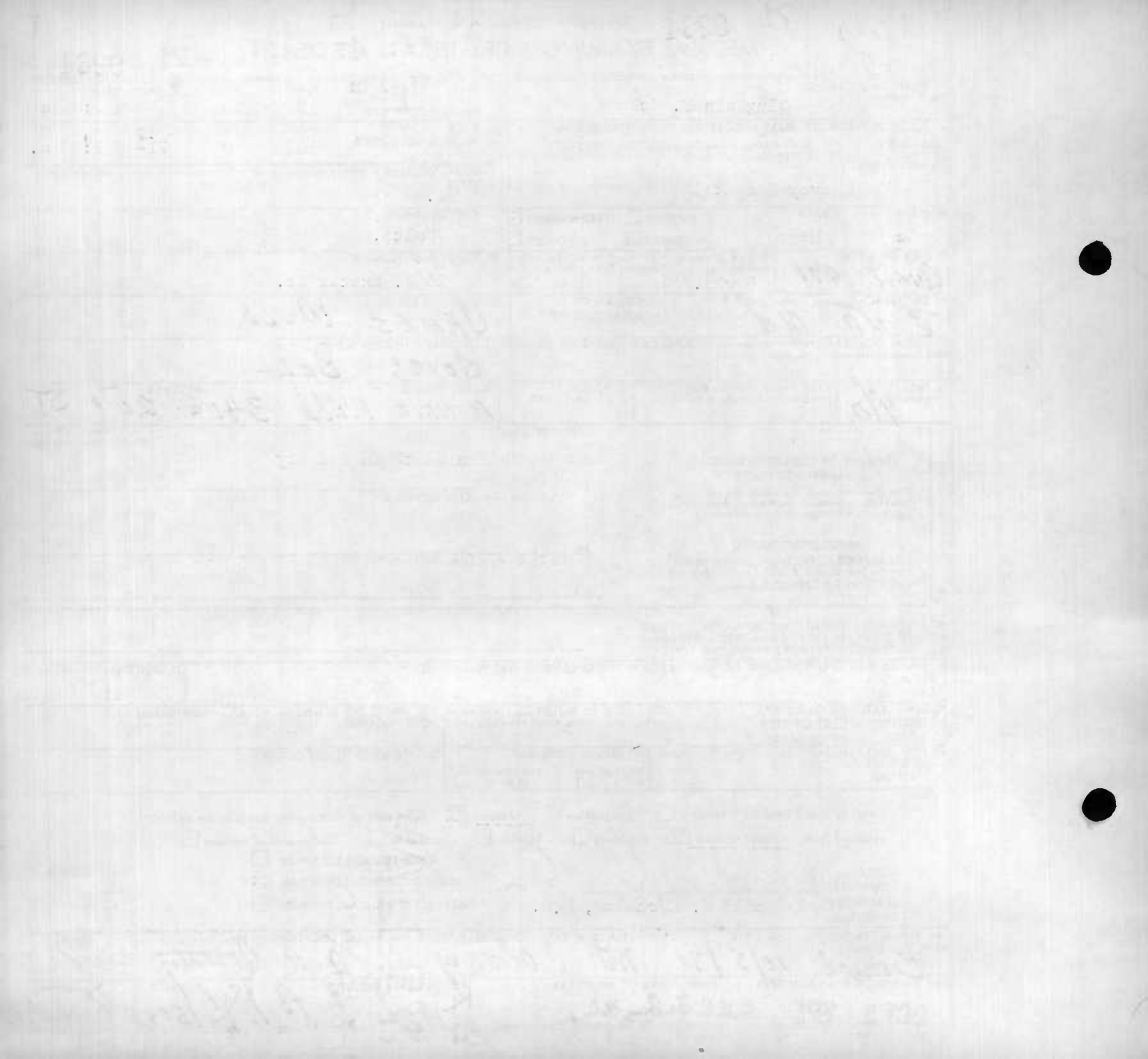
W-100 71 9234 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 9234

BIRTH NO. 71-13887

1. NAME OF DECEASED (Type or Print) Olugbala P. Webb		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 2 Year 71 Hour 7:00 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital		3. DATE PRONOUNCED DEAD Month 10 Day 2 Year 71 Hour 7:00 a.m.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Aug 17, 1971		10. AGE (In years last birthday) 6 wks.	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JAMES WEBB		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME JOYCE BELL		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT MINNIE WEBB ADDRESS 3408 20th ST	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Sudden death in infancy 795X		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 10/2/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/5/71	
24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) A.A. County, Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Joseph J. Locks		ADDRESS 1304 N. Central Ave	

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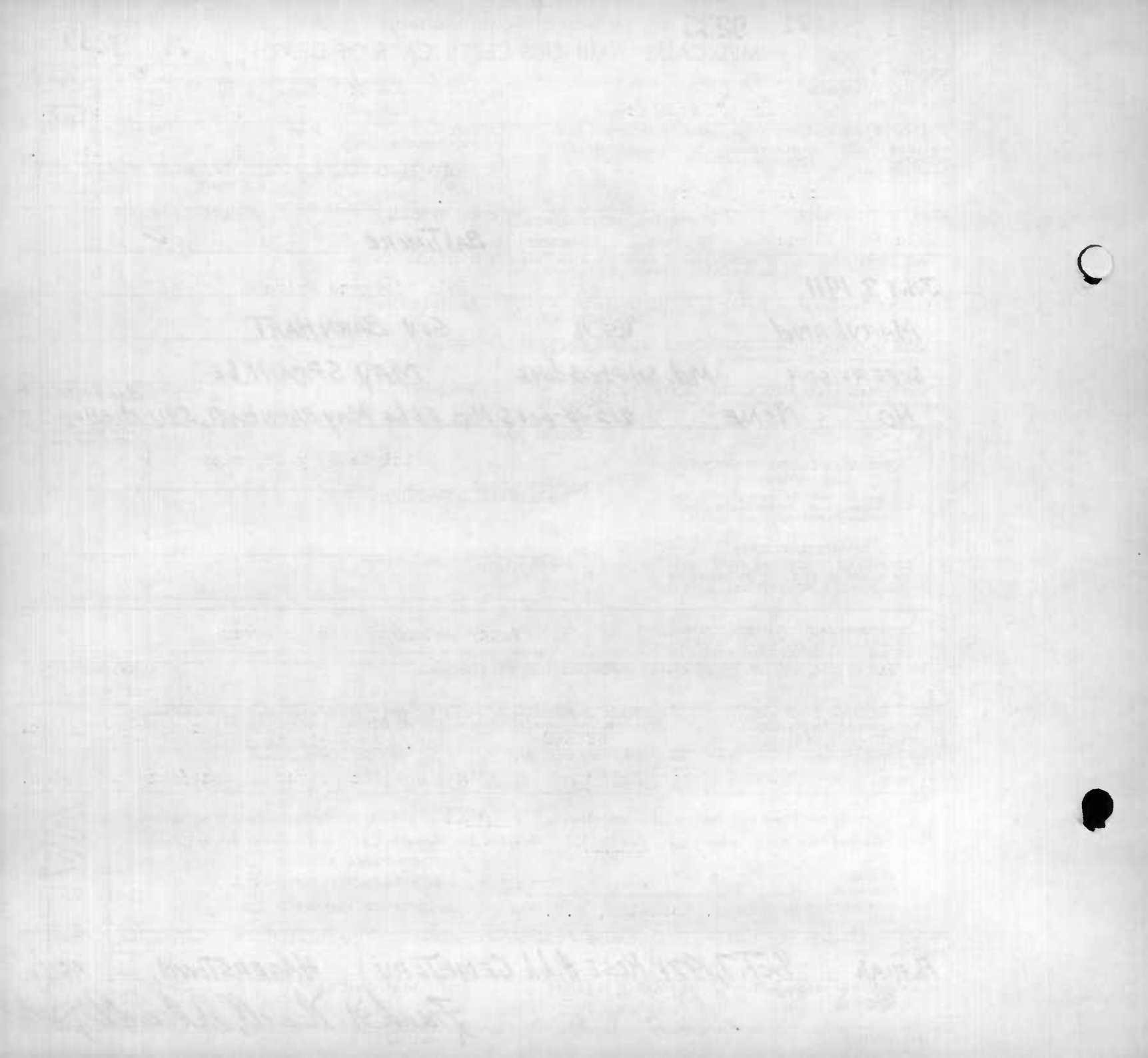
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 9235  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Vernon Barnhart		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 10 3 71 2:40 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 3 71 2:40 a.m.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN BALTIMORE	
9. DATE OF BIRTH July 3, 1911		10. AGE (In years last birthday) 60	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		14B. KIND OF BUSINESS OR INDUSTRY Md. SHIPBUILDING	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) NO NONE		17. SOCIAL SECURITY NO. 212-14-6065	
18. INFORMANT MRS. ELLA MAY BARNHART		ADDRESS BALTIMORE, Md. 5911 HIGHGATE DRIVE	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple body injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Fatty metamorphosis of liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2/10/71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET	
22D. TIME OF INJURY (APPROX.) 10 3 71 12:25 a.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1600 blk Hilton Pkwy- 550 ft. so. of Norris Lane		22F. HOW DID INJURY OCCUR? Subject driver in auto/auto collision.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE OCT. 7, 1971	
24C. NAME OF CEMETERY or CREMATORY ROSE HILL CEMETERY		24D. LOCATION (City, town, or county) (State) HAGERSTOWN, Md.	
25A. DATE RECD BY HEALTH DEPT. OCT 15 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR Frank H. Howell, Pikesville, Md.		25D. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred at the hospital by a medical examiner. Also, if the direct or contributory cause of death was (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined; (5) D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance prior to death); and (6) No physician was in regular attendance on the deceased, written approval must be obtained before the remains are embalmed or final disposition is made.

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<div style="display: flex; justify-content: space-between;"> <span>T-620 71 9236</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>71 9236</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="font-size: 2em;">X</span>	
1. NAME OF DECEASED (Type or Print) <b>ROLAND TRACEY</b>		2. DATE AND HOUR OF DEATH <b>9/30/71</b> <b>11:00 P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL of BALT. INC.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>	
5. SEX <b>M</b>		6. RACE <b>C</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 22, 1911</b>	
9. AGE (In years last birthday) <b>60</b>		10. AGE (In years last birthday) <b>60</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL R. TRACEY</b>		14. MOTHER'S MAIDEN NAME <b>ADA HEDRICK</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b> <b>NONE</b>		16. SOCIAL SECURITY NO. <b>213-10-1852</b>	
17. INFORMANT <b>MRS. Frances E. Tracey</b>		ADDRESS <b>PIKESVILLE, 620 MILITARY AVE.</b>	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p><b>I</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 35%;"> <p><b>(A) IMMEDIATE CAUSE</b>  <b>Carcinoma of the Lung C</b>  <b>possible cerebral metastases</b></p> <p><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b></p> <p><b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b></p> </div> </div> <p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <b>7 months</b></p>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>9/30</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/30</b> 19 <b>71</b> to <b>9/30</b> 19 <b>71</b> and that (I) (we) last saw the deceased alive on <b>9/30</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Veneranda C. Gerasmio</b>		23B. DATE SIGNED <b>9/30/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Veneranda C. Gerasmio</b>		23D. ADDRESS <b>SINAI HOSP. of BALT. INC.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>Oct. 4, 1971</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>CRESTMAWN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, HOWARD MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Frank J. Newell, Baltimore, Md.</b>		ADDRESS	

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X



BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GRACE ELIZABETH MONTANYE

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

off 2800 blk. Annapolis Road

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

September 29, 1971

6:00 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

BALTO 5300

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Glyndon

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

5/29/51

10. AGE (In years  
last birthday)

16

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

Box 14 Prospect Avenue

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CARLYLE N. MONTANYE

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

STUDENT

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

GRACE E. WHOLEY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

17. SOCIAL  
SECURITY NO.

Unknown

18. INFORMANT

M. Carlyle Montanye, Glyndon Md.

ADDRESS

19.

E960X

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Cerebro-cranial injuries  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

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20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

?

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

?

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

?

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Beaten by unknown assailant

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)Charles S. Springate M.D.  
Charles S. Springate, M.D.CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 30, 1971

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Oct. 2, 1971

24C. NAME OF CEMETERY or CREMATORY

Pikeville Ridge Cemetery

24D. LOCATION (City, town, or county)

Pikeville

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

OCT 5 1971

25B. NAME OF REGISTRAR

Robert E. Gibson, M.D.

25C. FUNERAL DIRECTOR

Frank H. Hensel

ADDRESS

Pikeville, Md.



10/5/71 - Birth certificate of child. 55-13646.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 9238</b>	
BIRTH NO. <b>P-620 71 9238</b>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Floried Parks</b>		2. DATE AND HOUR OF DEATH <b>10-2-71 9:35 A</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 Mercy Hospital</b>		A. STATE <b>Maryland</b>		B. COUNTY <b>2719</b>	
		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>5801 Park Heights Ave</b>			
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 22, 1927</b>	9. AGE (in years last birthday) <b>44</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Martini D.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Club</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
13. FATHER'S NAME <b>Daniel C. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Mary Pratt</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Rhinehart Parks</b> ADDRESS <b>3711 Gwynn Oak Ave</b>	
18. <b>412.21</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		<b>CARDIORESPIRATORY ARREST</b>			
[This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.]		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) PROBABLE CVA		12 hrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) ASCVD, Hypertension		YEARS	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>— 0 —</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>— 0 —</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>— 0 —</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>— 0 —</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>— 0 —</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 1</b> 19 <b>71</b> to <b>Oct 2</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>Oct 2</b> 19 <b>71</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Benedict A. Lerner, M.D.</b>		23B. DATE SIGNED <b>Oct 2 1971</b>		23C. PHYSICIAN'S NAME (Type) <b>DEGREE</b>	
23D. ADDRESS		23E. ADDRESS		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-7-71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem PK</b>	
24D. LOCATION (City, town, or county) <b>Arbutus</b>		24E. LOCATION (State) <b>MD</b>		25A. D. BY HEALTH DEPT. <b>OCT 5 1971</b>	
25B. NAME OF REGISTRAR <b>Joseph E. Parks</b>		25C. FUNERAL DIRECTOR <b>Joseph E. Parks</b>		25D. ADDRESS <b>2224 North Ave</b>	

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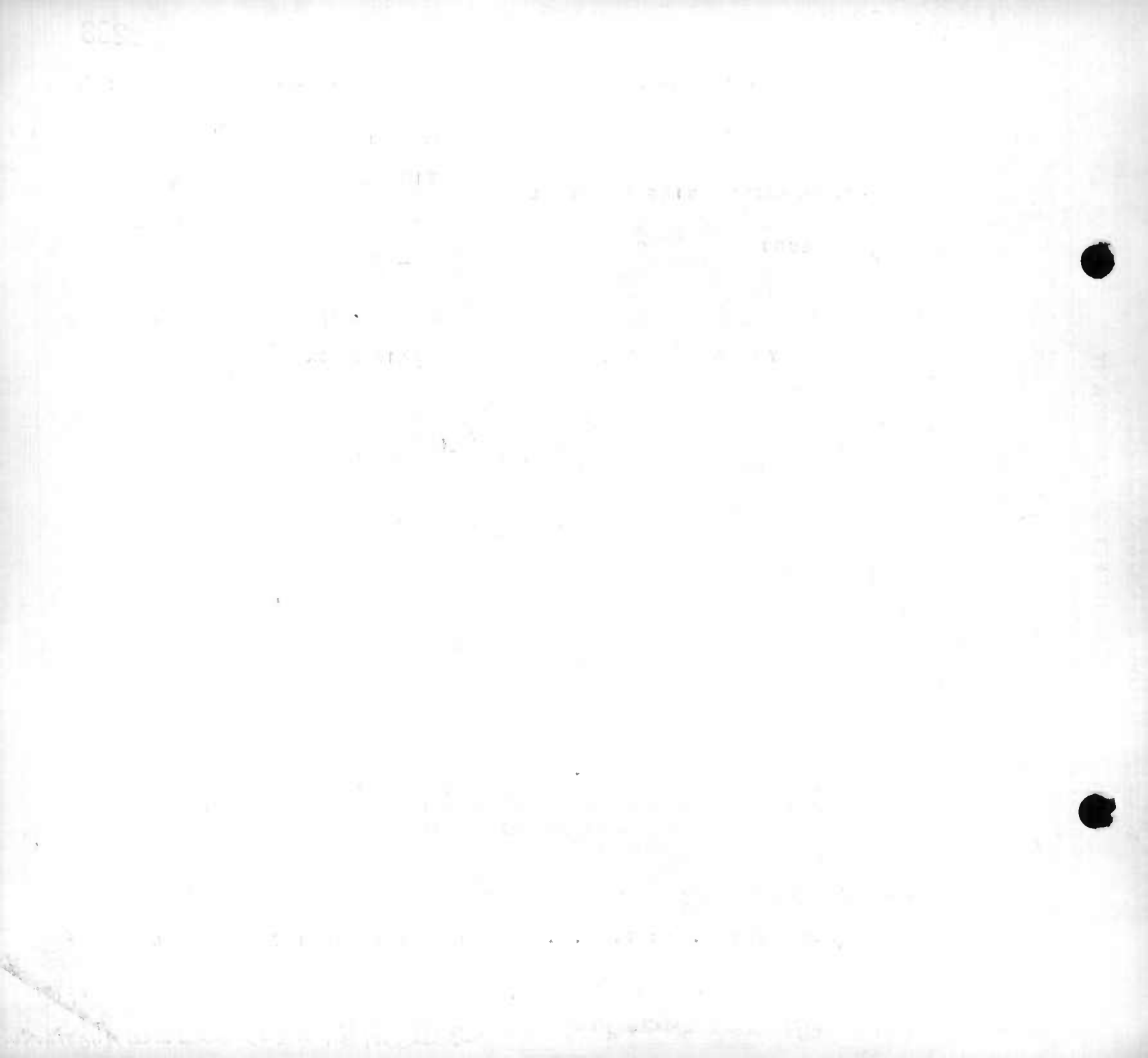
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-452 71 9239		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9239	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MARY ROLLINS		09-25-71		6:50P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND		B. COUNTY 1504	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2022 Ruxton Ave			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05-10-15	9. AGE (in years last birthday) 56	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James STUBBS Mack		14. MOTHER'S MAIDEN NAME MAMIE MACK Dent		12. CITIZEN OF WHAT COUNTRY? U.S.A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-22-1431		17. INFORMANT William Rollins 2022 Ruxton Ave	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Brain Tumor (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 1 1971 to Sept. 25 1971 that (I) (we) last saw the deceased alive on Sept. 25 1971 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Penelope P. Scott, M.D.		23B. DATE SIGNED 9/25/71		23C. PHYSICIAN'S NAME (Type) PENELOPE P. SCOTT M.D.	
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		23E. ATTENDING PHYSICIAN Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-29-71		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem	
24D. LOCATION Westport		24E. CITY, TOWN, OR COUNTY Md		24F. STATE Md	
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Joseph E. Run 2222 W. North Ave	
25D. ADDRESS		25E. CITY, TOWN, OR COUNTY		25F. STATE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 9240</u>	
G-600 71 9240		CERTIFICATE OF DEATH	
BIRTH NO. <u>71 9240</u>		1. NAME OF DECEASED (Type or Print) <u>GRAY ELIZABETH E.</u>	
2. DATE AND HOUR OF DEATH <u>10/1/71 7:00 PM.</u>		M. <u>1504</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital of Baltimore</u> <u>Belvedere Ave. at Greenspring - Baltimore</u> <u>Maryland.</u>		A. STATE <u>Mari land</u> B. COUNTY <u>1504</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2016 McKean Ave # 17.</u>	
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/15/09</u>
		9. AGE (In years last birthday) <u>62</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Nosp</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>ERNEST GRAY</u>		14. MOTHER'S MAIDEN NAME <u>BOSSY WALLACE</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>116-26-7058</u>	
		17. INFORMANT <u>Miss Owen Gray 2016 McKean Ave</u>	
		ADDRESS	
18. <u>162-1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Brain damage, pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Ca of the lung with brain</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>metastasis</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>10-6-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>August 16 1971</u> to <u>October 1 1971</u> that (I) (we) last saw the deceased alive on <u>October 1 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>E. Kalisky</u>		23B. DATE SIGNED <u>10/1/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. KALISKY</u>		23D. ADDRESS <u>Sinai Hospital of Baltimore</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-6-71</u>	
24C. NAME of CEMETERY or CREMATORY <u>Mt Auburn Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Westport Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.P.</u>	
25C. FUNERAL DIRECTOR <u>Joseph J. Russ</u>		ADDRESS <u>2222 North Ave</u>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-520 71 9241		BALTIMORE CITY HEALTH DEPARTMENT		71 9241	
BIRTH NO. 71-15218		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Simms, Nichole</u>			2. DATE AND HOUR OF DEATH <u>10-2-71</u> <u>2:25</u> <u>Am</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University Hospital</u> <u>Green St. Balto. md.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>AA</u> C. CITY OR TOWN <u>Baltimore md</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>Box 192 Rt # 2</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-5-71</u>	9. AGE (In years last birthday) <u>4 wks.</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>Charles Simms</u>			14. MOTHER'S MAIDEN NAME <u>Roseitha Brown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>009.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH - <u>Gregory 10-2-71 6:45 am</u> <u>M. E. Anaxion Aplexia</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Dehydration</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Gastroenteritis</u> (C) <u>10 min.</u> <u>24 hrs.</u> <u>1 week</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/2</u> 19 <u>71</u> to <u>10/2</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10/2</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles B. Hargrove MD</u>				23B. DATE SIGNED <u>10/2/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Charles B. Hargrove MD</u>				23D. ADDRESS <u>William Rees</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-4-1971</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Calvary</u>	
24D. LOCATION (City, town, or county) <u>Arnold</u>		24E. NAME OF REGISTRAR <u>William Rees</u>		24F. FUNERAL DIRECTOR <u>William Rees</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 5 1971</u>		25B. NAME OF REGISTRAR <u>William Rees</u>		25C. FUNERAL DIRECTOR <u>William Rees</u>	

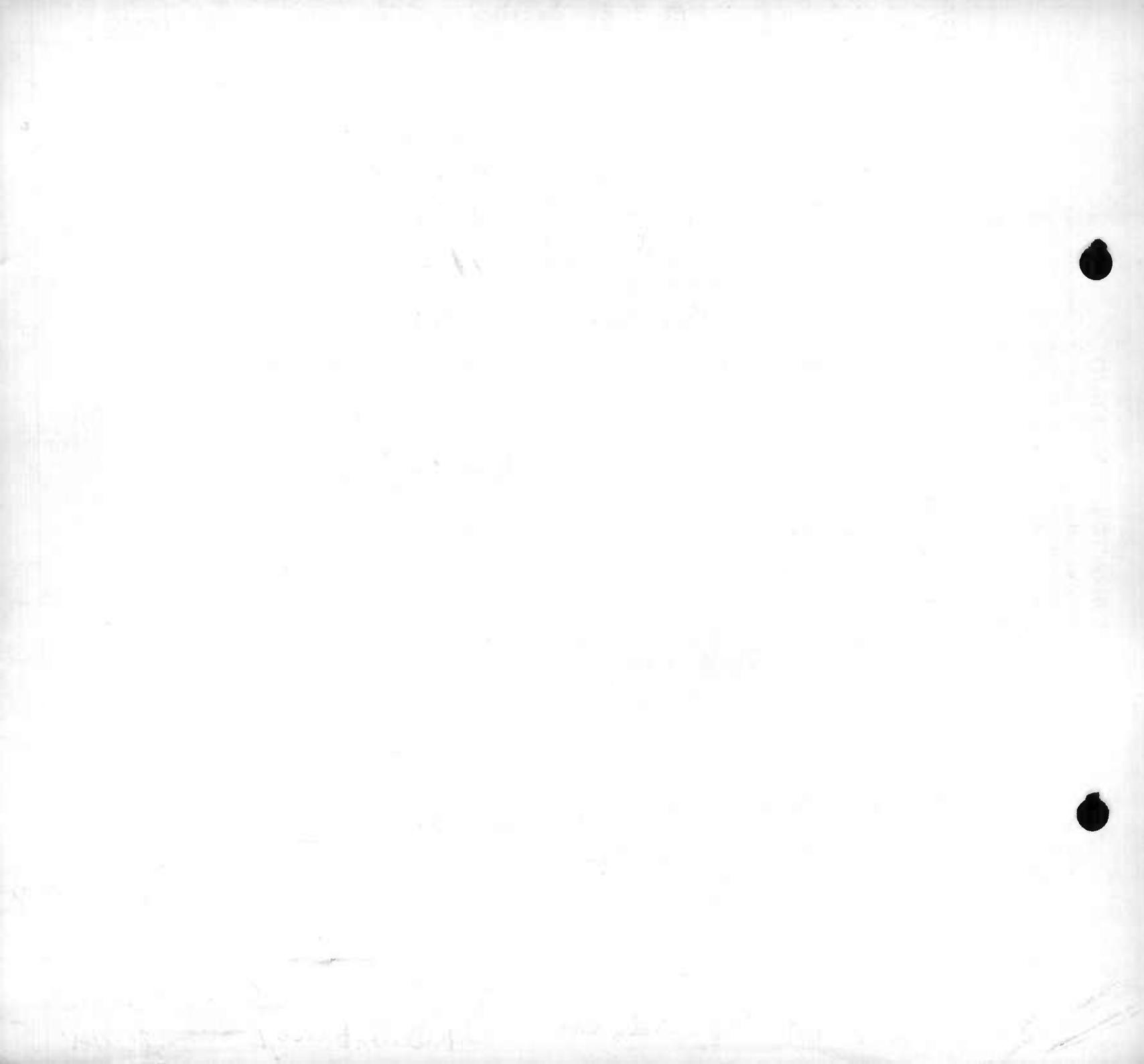




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

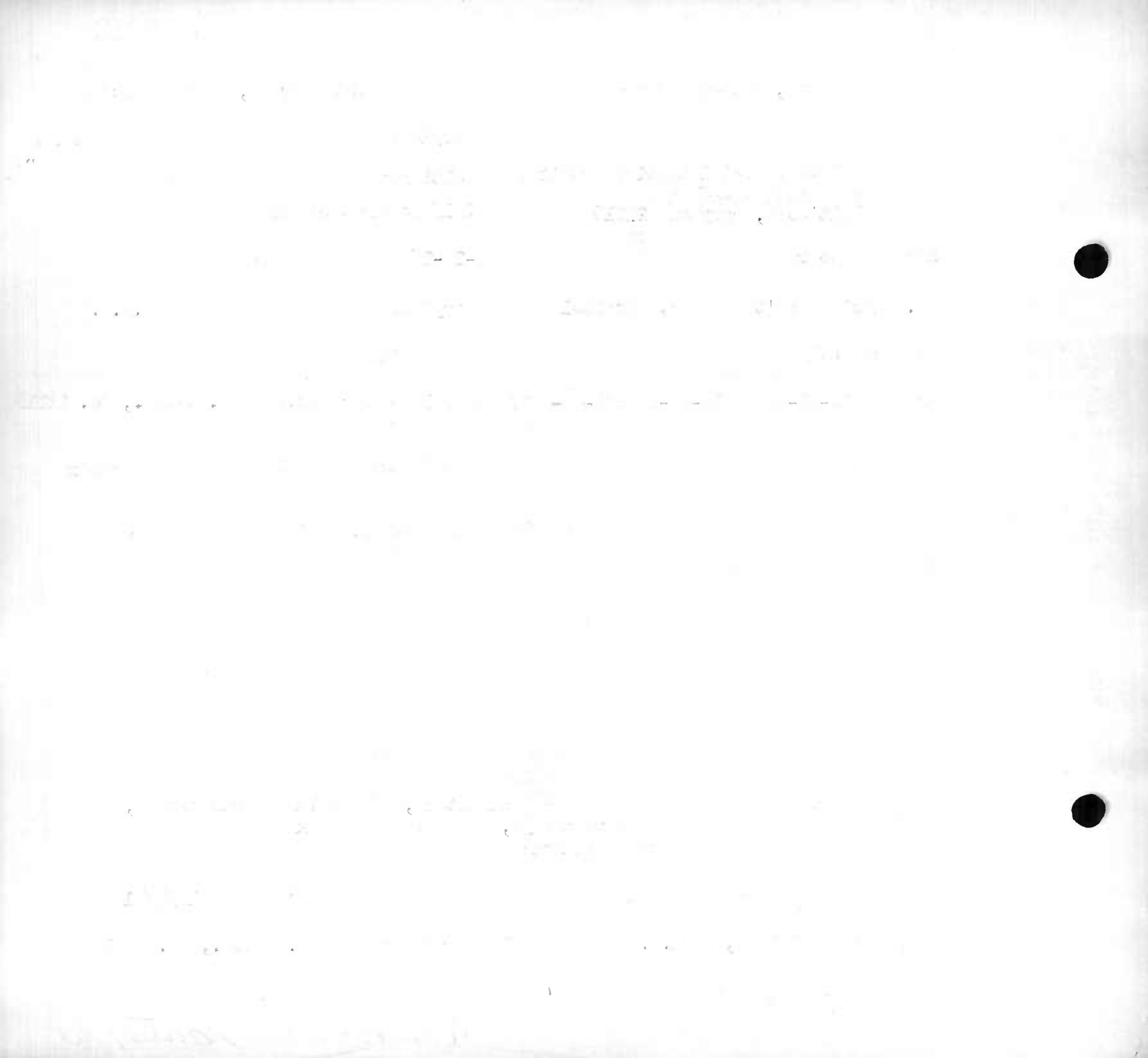
D-620 71 9242		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 71 9242	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>DORSEY, MERRILL</b>				20 October 1971 5:10 PM EDT M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
The Johns Hopkins Hospital		BALTIMORE, Md 21205		MARYLAND		Anne Arundel	
C. CITY OR TOWN		D. INSIDE CITY LIMITS?		E. STREET AND NUMBER			
Gambrells		YES <input type="checkbox"/> NO <input type="checkbox"/>		RT 24			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months	11. If Under 24 Hrs. Days	12. If Under 24 Hrs. Hours
MALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	18-3-25	45			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Plumber				Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Dorsey				Annice Rawlings			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
						John Jones - Crownsville, Md	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				increased intracranial pressure 1 month			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>arteriovenous malformation of brain</i> 5 mos or longer			
II				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				pneumonia			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
114 Sept 1971		Brain tumor		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		White AI <input type="checkbox"/> Not White AI Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 31 August 1971 to 2 October 1971 that (I) (we) last saw the deceased alive on 20 October 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Edward Sperber MD						2 October 1971	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
EDWARD SPERBER MD				The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/7/71		Wilson Memorial		Gambrells A.C. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 5 1971		Robert E. Fisher, R.D.		William Reese, Jr. - Annapolis, Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9243</u>	
BIRTH NO. <u>H-400 71 9243</u>					
1. NAME OF DECEASED (Type or Print) <u>HALL, Andrew Richard</u>		2. DATE AND HOUR OF DEATH <u>September 30, 1971 12:30 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1513</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>23 Veterans Administration Hospital</u> <u>3900 Loch Raven Blvd</u> <u>Baltimore, Maryland 21218</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2515 Loyola Northway</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-28-25</u>	9. AGE (In years last birthday) <u>46</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Nursing Ass't</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>VAH, Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wallace Hall</u>			
14. MOTHER'S MAIDEN NAME <u>Mary White</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <u>10-13-43 to 12-23-45</u>			
16. SOCIAL SECURITY NO. <u>212-20-8438</u>		17. INFORMANT <u>Records</u> ADDRESS <u>VAH, 3900 Loch Raven Blvd. Balto., Md. 21218</u>			
18. <u>205.1 I</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ACUTE BLASTIC CRISIS</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		<u>3 weeks</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>CHRONIC MYELOGENOUS LEUKEMIA</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>8 yrs</u>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Yes</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>August 24, 19 71</u> to <u>September 30, 19 71</u> that (2) (we) last saw the deceased alive on <u>September 30, 19 71</u> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.					
23A. SIGNATURE <u>Joseph Sappington</u> M.D.				23B. DATE SIGNED <u>10/1/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOSEPH SAPPINGTON, M.D.</u>				23D. ADDRESS <u>3900 Loch Raven Blvd. Balto., Md. 21218</u>	
24A. BURIAL-CREATION, REMOVAL (Specify)		24B. DATE <u>10-5-71</u>		24C. NAME of CEMETERY or CREMATORY <u>White</u>	
24D. LOCATION (City, town, or county)		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 5 1971</u>		25B. NAME OF REGISTRAR <u>Walter J. Brantley</u>		25C. FUNERAL DIRECTOR <u>Walter J. Brantley</u>	
25D. ADDRESS					



BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

BIRTH NO. P-200 71 9244 REG. NO. 71 9244

1. NAME OF DECEASED (Type or Print) <b>Robert Lee Pace</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <u>10</u> Day <u>2</u> Year <u>71</u> Hour <u>1:55</u> p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37</u> <b>Mercy Hospital</b>		3. DATE PRONOUNCED DEAD Month <u>10</u> Day <u>2</u> Year <u>71</u> Hour <u>1:55</u> p.m.	
6. SEX <u>male</u>		7. RACE <u>Negro</u>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Harford Avenue</u>	
9. DATE OF BIRTH <u>11-26-1926</u>		10. AGE (In years last birthday) <u>44</u> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		15. MOTHER'S MAIDEN NAME <u>Bearab Pace</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u>		17. SOCIAL SECURITY NO. <u>May Pace 2917 Edgewood Ave</u>	
19. <u>E96501X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  GunsHOT wound of abdomen (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>HOME</u>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>1038 Harford Ave. (hallway)</u>		22F. HOW DID INJURY OCCUR? <u>Subject shot by unknown assailant</u>	
22D. TIME OF INJURY (APPROX.) Month <u>10</u> Day <u>2</u> Year <u>71</u> Hour <u>unk</u>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Ronald N. Kornblum</u> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <u>10/3/71</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-6-71</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Cmt</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Edwards &amp; Cranley Inc</u>		ADDRESS	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9245

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

James A. Hudson

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month 10 Day 3 Year 71

Hour 1:44 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

43 So. Balto. Gen. Hospital

3. DATE  
PRONOUNCED DEAD

Month 10 Day 3 Year 71

Hour 1:44 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Md.

B. COUNTY

AA

5200

6. SEX

male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Millersville

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

JUNE 18, 1934

10. AGE (In years  
last birthday)

37

11. Under 1 Yr. 11 Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

ARUNDEL CO.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Hudson

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

LABORER

14B. KIND OF BUSINESS OR INDUSTRY

CONSTRUCTION

15. MOTHER'S MAIDEN NAME

Ollie Hudson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)

yes

17. SOCIAL  
SECURITY NO.

215-30-5621

18. INFORMANT

Ollie Hudson Same

ADDRESS

19. E966X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Stab wound of chest

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

House

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1019 S. Hanover Street

22D. TIME  
OF INJURY  
(APPROX.)

(Month) 10 (Day) 3 (Year) 71 (Hour) 1:00

(Min.) a.m.

(Year) 71

(Hour) 1:00

(Min.) a.m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Stabbed during altercation.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒ XX  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
10/3/7124A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10-6-71

24C. NAME OF CEMETERY or CREMATORY

Halls Cont

24D. LOCATION (City, town, or county)

AA County Md

25A. DATE REC'D BY HEALTH DEPT.

OCT 5 1971

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Clayton 1000 Brantley Ln

ADDRESS

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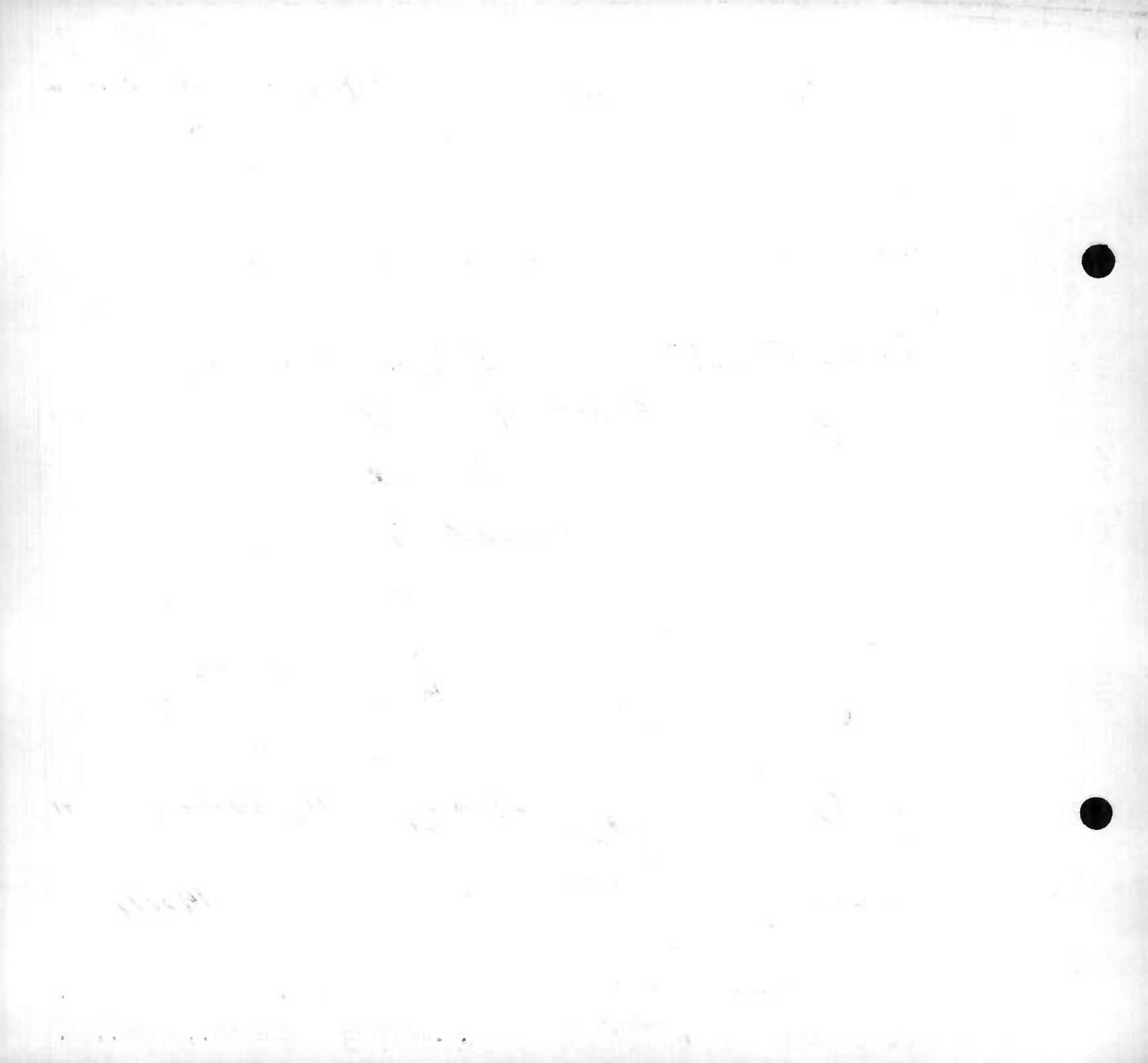
BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 71 9246			
BIRTH NO. 71 9246											
1. NAME OF DECEASED (Type or Print) <b>EARNEST ERNEST JOHNSON</b>				2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>				Month Day Year Hour			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 Johns Hopkins Hospital</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 3 1971 1:15 p.m.</b>				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>804</b>			
6. SEX <b>male</b>		7. RACE <b>negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH <b>11-10-1918</b>		10. AGE (In years last birthday) <b>52</b>		11. BIRTHPLACE (State or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		E. STREET AND NUMBER <b>2304 E. Oliver St.</b> <b>1970 N. Patterson Park Ave.</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				14B. KIND OF BUSINESS OR INDUSTRY <b>?</b>				13. FATHER'S NAME <b>UNKNOWN</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>?</b>				17. SOCIAL SECURITY NO. <b>?</b>				15. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
18. INFORMANT <b>Lillian Wilson</b>				ADDRESS <b>2521 E. Oliver St.</b>							
19. <b>E966X1</b>				CAUSE OF DEATH <b>Stab wound of chest</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) _____							
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>							
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) <b>home</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1970 N. Patterson Park Ave.</b>		22D. TIME (Month) (Day) (Year) (Hour) <b>10-3-71 12:40 p.m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Stabbed by assailant.</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>10-4-71</b>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-7-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>McCALVARY Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Co., Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1971</b>		25B. NAME OF REGISTRAR <b>Rafael E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Randolph J. Collick</b>		ADDRESS <b>2431 E. Oliver St.</b>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 9247	
BIRTH NO. 71 9247					
1. NAME OF DECEASED (Type or Print) <b>ECKERT, ROY ALLEN</b>		2. DATE AND HOUR OF DEATH <b>October 3, 1971 7:10 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE <b>FLORIDA</b> B. COUNTY <b>V08</b> C. CITY OR TOWN <b>HOLLYWOOD (BROWARD County)</b> D. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1644 JACKSON ST.</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5/6/01</b>	9. AGE (in years last birthday) <b>70</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ACCOUNTANT</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N.Y.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Eckert</b>			
14. MOTHER'S MAIDEN NAME <b>Lillian Manning</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>042-09-2047</b>		17. INFORMANT ADDRESS <b>E. W. ECKERT, MIAMI, FLA.</b>			
18. <b>287.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Remembrance</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <b>Remembrance</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>October 2</b> 19 <b>71</b> to <b>October 3</b> 19 <b>71</b> that (1) (we) last saw the deceased alive on <b>Oct 3</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Harold Helderman</b> DEGREE		23B. DATE SIGNED <b>10/3/71</b>		23C. PHYSICIAN'S NAME (Type) <b>J. HAROLD HELDERMAN, M.D.</b>	
23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>	24B. DATE <b>10-4-71</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1971</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co., Balto., Md.</b>			



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BALTIMORE CITY HEALTH DEPARTMENT

71 9248

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9248

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LARRY GRAY FERRELL (TERRELL)</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3701 Beehler Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>10 3 1981</b> 11:15 p.m.	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>July 7, 1952</b>		10. AGE (In years last birthday) <b>19</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF <b>WHAT COUNTRY?</b> <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mrs. Barbara Kilgore</b>		ADDRESS <b>3708 Beehler Avenue</b>	

19. <b>E965X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <b>Gunshot wound of chest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					

20A. DATE OF OPERATION <b>10-3-71</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>unknown</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Unknown - Found rear 3701 Beehler Ave.</b>	
22D. TIME OF INJURY (APPROX.) <b>10-3-71</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot by assailant.</b>	

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE **Russell S. Fisher** M.D.  
EXAMINER'S NAME (Type) **Russell S. Fisher, M.D.**

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED  
**10-4-71**

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-8-71</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1981</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Morton &amp; Dyett F. H. 1701 Laurens St.</b>			

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71 9249

## BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9249

1. NAME OF DECEASED (Type or Print) <b>WALTER KING</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital (DDA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 3 1971 6:15 PM</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>2-29-28</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) <b>43</b>		E. STREET AND NUMBER <b>3940 Oakford Ave.</b>	
11. BIRTHPLACE (State or foreign country) <b>Martinsville, Virginia</b>		12. CITIZEN OF <b>U.S.A.</b>	
13. FATHER'S NAME <b>Marshall King</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction</b>	
15. MOTHER'S MAIDEN NAME <b>Lucy Ann King</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>215-28-8983</b>		18. INFORMANT <b>Leona Hairston</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10-4-71</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-7-71</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett F. H.</b>		25D. ADDRESS <b>1701 Laurens St.</b>	

BASE II

BASE II

UNIT 1 & 2 PAPER CO

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9250

BIRTH NO.

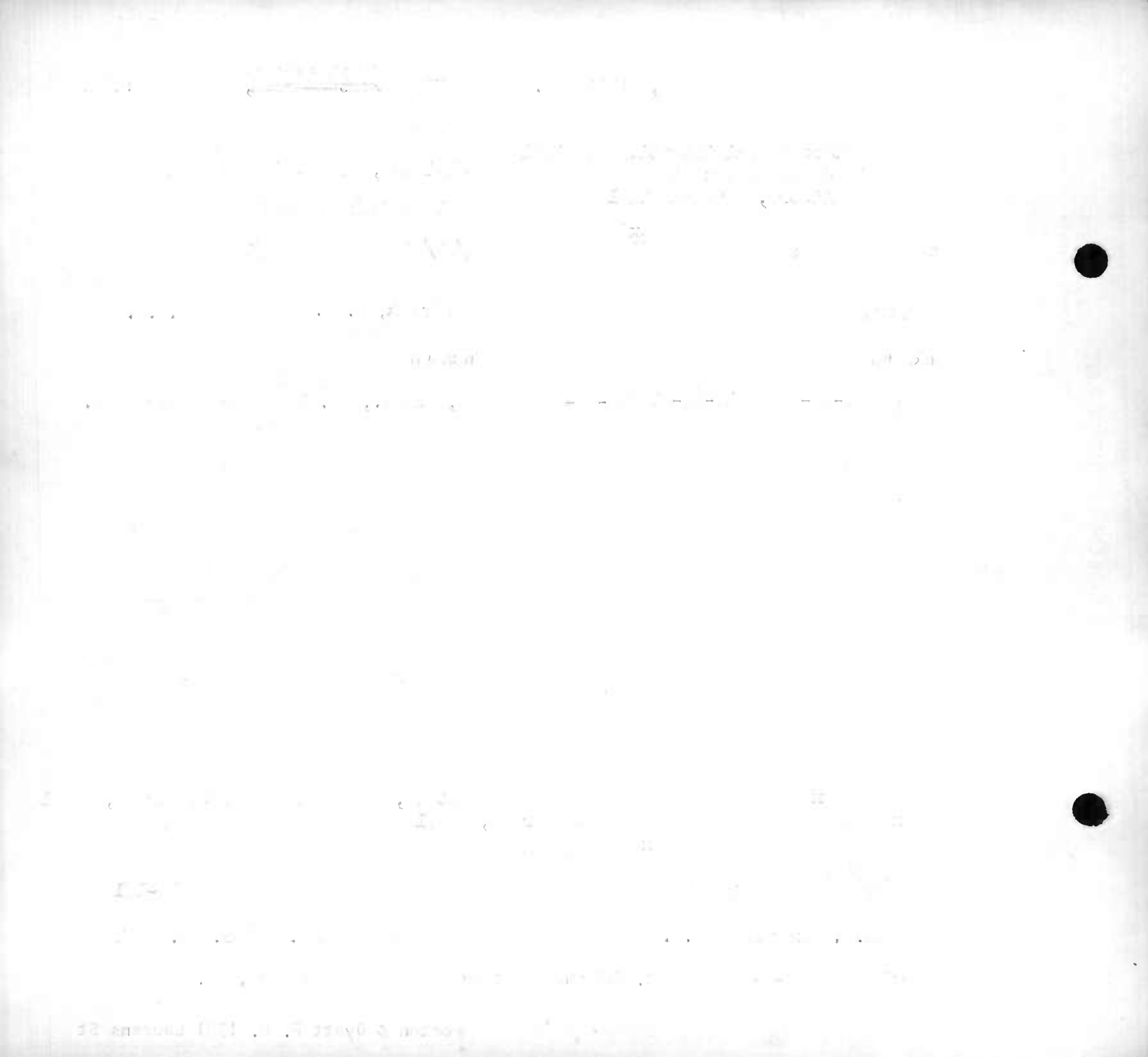
1. NAME OF DECEASED (Type or Print) Bernard Sutton		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 10 2 71 11:55 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2824 W. Cold Spring Lane		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 2 71 11:55 a.m.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 2-18-24		10. AGE (In years last birthday) 46	
11. BIRTHPLACE (State or foreign country) Northumberland Co., Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electric Motor Co.		15. MOTHER'S MAIDEN NAME Ruth Taylor	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 225-20-7686	
18. INFORMANT Ruth Davis 3301 Ferndale		ADDRESS	
19. 571.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/3/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-81-71	
24C. NAME OF CEMETERY or CREMATORY Gallie A. M. E. Cemetery		24D. LOCATION (City, town, or county) (State) Northumberland Co., Va.	
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1971		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Morton & Dyett F. H.		ADDRESS 1701 Laurens St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

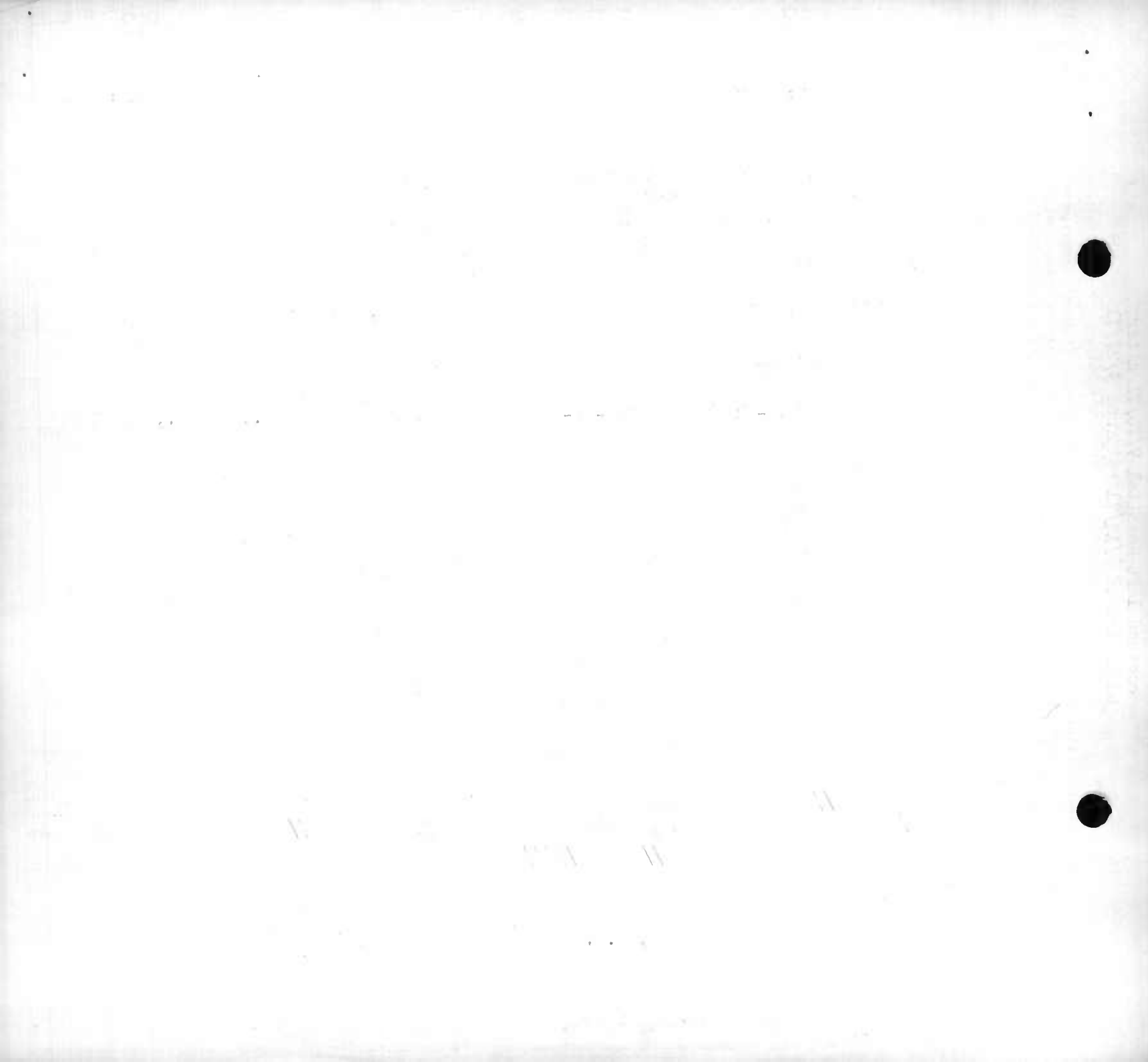
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9251</u>	
CERTIFICATE OF DEATH					
BIRTH NO. <u>71 9251</u>					
1. NAME OF DECEASED (Type or Print)		WALKER, William R.		2. DATE AND HOUR OF DEATH <u>OCT 1, 1971</u> <u>5:45 A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1509</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>23</u> <u>Veterans Administration Hospital</u> <u>3900 Loch Raven Blvd</u> <u>Baltimore, Maryland 21218</u>		C. CITY OR TOWN <u>Baltimore, Maryland</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>4001 Norfolk Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/13/19</u>	9. AGE (In years last birthday) <u>52</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pembroke, N. C.</u>	
13. FATHER'S NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>1-12-42 to 12-14-42</u>		16. SOCIAL SECURITY NO. <u>212-16-4080</u>		17. INFORMANT <u>Records</u> ADDRESS <u>VAH, Balto., Md. 3900 Loch Raven Blvd.</u>	
18. <u>686,91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CARDIORESP ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>BILAT. BRONCHO PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>INFECTION, (L) HIP PROTHESIS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN</u> <u>2 wks.</u> <u>6 mos.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if this hospital) attended the deceased from <u>August 26,</u> 19 <u>71</u> to <u>September 30,</u> 19 <u>71</u> that (if we) last saw the deceased alive on <u>September 30,</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) did) <u>X</u> view the body after death.					
23A. SIGNATURE <u>L.B. Barnett, MD</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>10-171</u>	
23C. PHYSICIAN'S NAME (Type) <u>L.B. Barnett M.D.</u>		23D. ADDRESS <u>3900 Loch Raven Blvd. Balto. Md. 21218</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-6-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Morton &amp; Dyett F. H.</u>	
				ADDRESS <u>1701 Laurens St</u>	



deceased left hospital 9/26/71 after admission of 8/12/71 returned 9/27/71  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

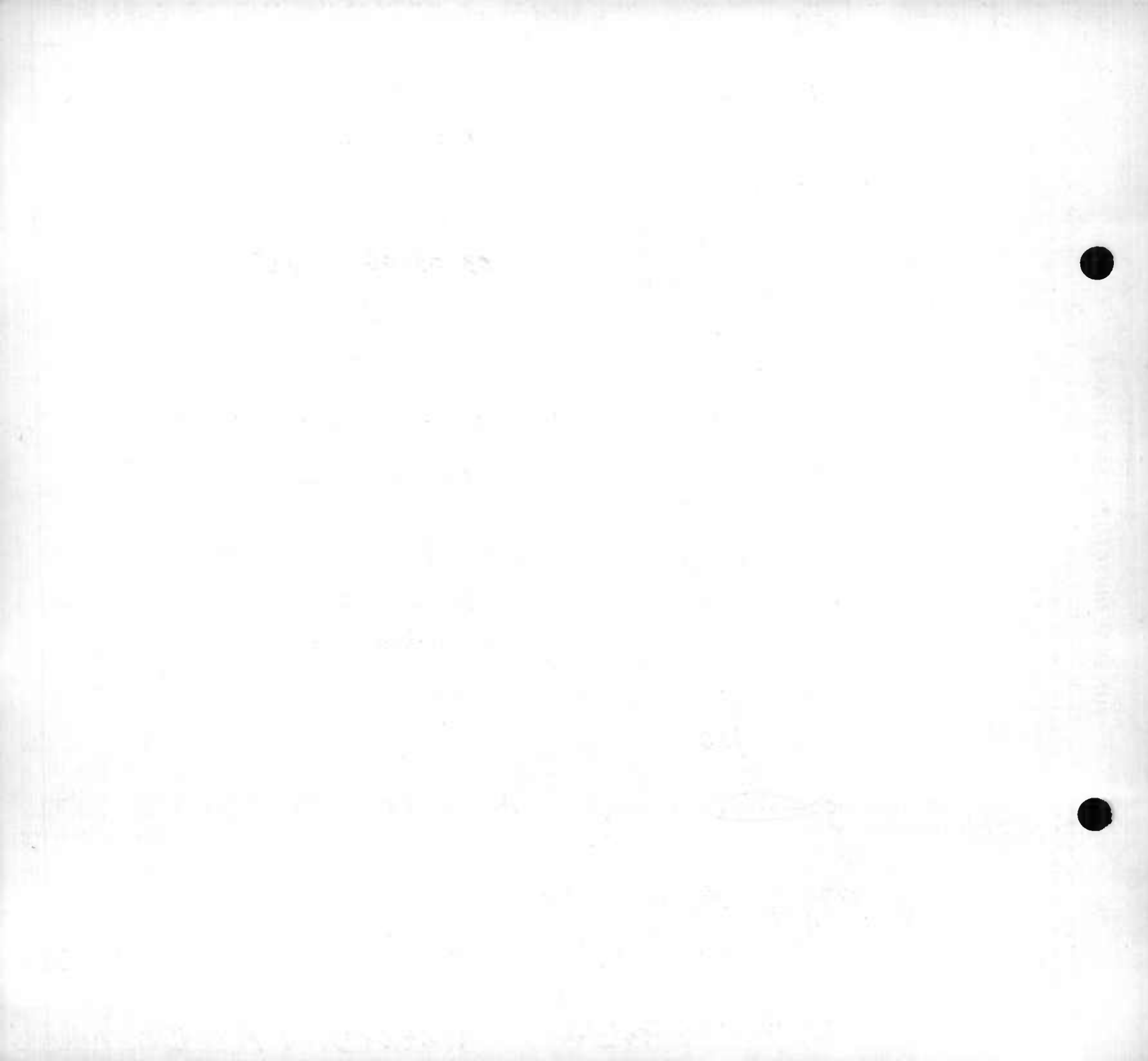
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 9252	
BALTIMORE CITY HEALTH DEPARTMENT					
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CHASE, JOHN M			
2. DATE AND HOUR OF DEATH 9/28/71 10:30 A M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1703			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 2128		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior Decorator		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 43	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Benjamin Marcell		14. MOTHER'S MAIDEN NAME Grace Chase			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 3/18/46 - 12/26/46		16. SOCIAL SECURITY NO. 216-24-7542		17. INFORMANT VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 436.01		CAUSE OF DEATH (A) IMMEDIATE CAUSE Gastric hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (B) Esophageal varices DUE TO, OR AS A CONSEQUENCE OF: (C) Post-hepatic necrosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 hr. ± 1 yr. > 1 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). acute cerebral edema					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (u) (this hospital) attended the deceased from 9/27 19 71 to 9/28 19 71 that (u) (we) last saw the deceased alive on 9/28 19 71 and that in (u) (our) opinion death occurred on the date and hour and from the causes stated above. (u) (We) (did) (u) (we) view the body after death.					
23A. SIGNATURE Rudolph W Koster M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) RUDOLPH W KOSTER, M.D.				23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-4-71		24C. NAME OF CEMETERY OR CREMATORY GETTYSBURG, NATIONAL	
24D. LOCATION GETTYSBURG, PENNSYLVANIA					
25A. DATE REC'D. BY HEALTH DEPT. OCT 5 1971		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR MORTON & DYATT F.H. 1701 LAURENS ST.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9253</u>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>Paul Bailey</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>10:45 AM Oct 1, 1971</u>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <u>The Johns Hopkins Hospital</u> <u>333</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>-</u> <b>C. CITY OR TOWN</b> <u>Baltimore</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>601 No. B</u> <u>926 N. PAYSON ST.</u>			
<b>5. SEX</b> <u>M</u>	<b>6. RACE</b> <u>N</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>03-03-06</u> <b>9. AGE</b> (In years last birthday) <u>65</u> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>10B. KIND OF BUSINESS OR INDUSTRY</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Balto MD</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Clarence Yates</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Emma Bailey</u>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>216-01-6332</u>		<b>17. INFORMANT</b> <u>John Bailey</u> <b>ADDRESS</b> <u>926-N-PAYSON ST</u>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>19A. DATE OF OPERATION</b> <u>28-23-71</u> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <u>Hyperbilirubinemia</u> <b>20A. AUTOPSY?</b> (Yes or No) <u>Yes</u> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <u>NO</u> <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/> <u>No</u> <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>21F. HOW DID INJURY OCCUR?</b> <b>22. I certify that</b> (1) <u>this hospital</u> attended the deceased from <u>August 22</u> 19 <u>71</u> to <u>Oct 1</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Oct 1</u> 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. <b>23A. SIGNATURE</b> <u>George J. Taylor</u> <b>23B. DATE SIGNED</b> <u>10-1-71</u> <b>23C. PHYSICIAN'S NAME</b> (Type) <u>George J. Taylor MD</u> <b>23D. ADDRESS</b> <u>The Johns Hopkins Hospital, Baltimore Md</u> <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u> <b>24B. DATE</b> <u>10-5-71</u> <b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>Mt Auburn</u> <b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore, MD</u> <b>25A. DATE REC'D BY HEALTH DEPT</b> <u>OCT 5 1971</u> <b>25B. NAME OF REGISTRAR</b> <u>Robert E. Taylor</u> <b>25C. FUNERAL DIRECTOR</b> <u>Horton Dyett F.H. 1701-LAWRENCE ST</u>					





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>71 9254</b>	
BIRTH NO. <b>71 9254</b>		1. NAME OF DECEASED (Type or Print) <b>Hallie Edney Perry</b>		2. DATE AND HOUR OF DEATH <b>9-28-71 2:50 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital, Inc. 2600 Liberty Heights Ave. Baltimore, Maryland 21215</b> <b>39</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1703</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b>		6. RACE <b>Black</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>7-6-25</b>		9. AGE (in years last birthday) <b>46</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <b>Connecticut, Harford</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Alexander Edney</b>	
14. MOTHER'S MAIDEN NAME <b>None Hallie V. Edney</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>042-20-2219</b>	
17. INFORMANT <b>Jones</b>		18. ADDRESS <b>1303 Argyle Ave. 2229 Callow Ave.</b>		19. NAME <b>Frances Kennedy Sister</b>	
18. <b>425X I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE</b> <i>Congestive Cardiac Failure</i> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B)</b> <i>Cardiomyopathy</i> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C)</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week.</i> <i>10 years</i> <i>10 years</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Hypertension</i>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-28</b> <b>19 71</b> to <b>19 71</b> that (I) (we) last saw the deceased alive on <b>19 71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M. J. Shafi</i>				23B. DATE SIGNED <b>9/30/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Shafi</b>				23D. ADDRESS <b>2600 Liberty Heights Ave. Balto, Md. 21215</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-5-71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24E. STATE (State) <b>Maryland</b>		24F. COUNTY (County) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>		25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett F. H.</b>	
25D. ADDRESS <b>1701 Laurens St.</b>		25E. CITY <b>Baltimore</b>		25F. STATE <b>Md.</b>	



L 200

71 9255

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9255

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William A. Laws, Sr.

2. DATE  
OF DEATHKnown ☒ Estimated ☐

Month Day

Year

Hour

10:30 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If not in hospital or institution, give street  
address or location)

529 Bloom Street

3. DATE  
PRONOUNCED DEAD

Month Day

Year

Hour

10:30 p.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE  
Md.

B. COUNTY

1403

6. SEX

male

7. RACE

Negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

March 31, 1947

10. AGE (In years  
lost birth day)

24

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

529 Bloom Street

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF

WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Unknown

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14b. KIND OF BUSINESS OR INDUSTRY

Retail

15. MOTHER'S MAIDEN NAME

Lucinda Laws

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)

No

No

17. SOCIAL  
SECURITY NO.

229-58-9773

18. INFORMANT

Bloom

ADDRESS

Eunice Laws 529 Bloom Street

19. E 955X1

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Gunshot wound of chest

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

HOME

22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?

529 Bloom Street

22D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

9

30

71

unk.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

Subject shot himself.

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/1/71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10-7-71

24C. NAME of CEMETERY or CREMATORY

Beacon Bapt. Ch. Cem.

24D. LOCATION (City, town, or county)

Warsaw,

Virginia

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MORTON &amp; DYETT F.H. 1701 Laurens Street

1000

1000

1000

1000

1000

1000

1000

1000

1000

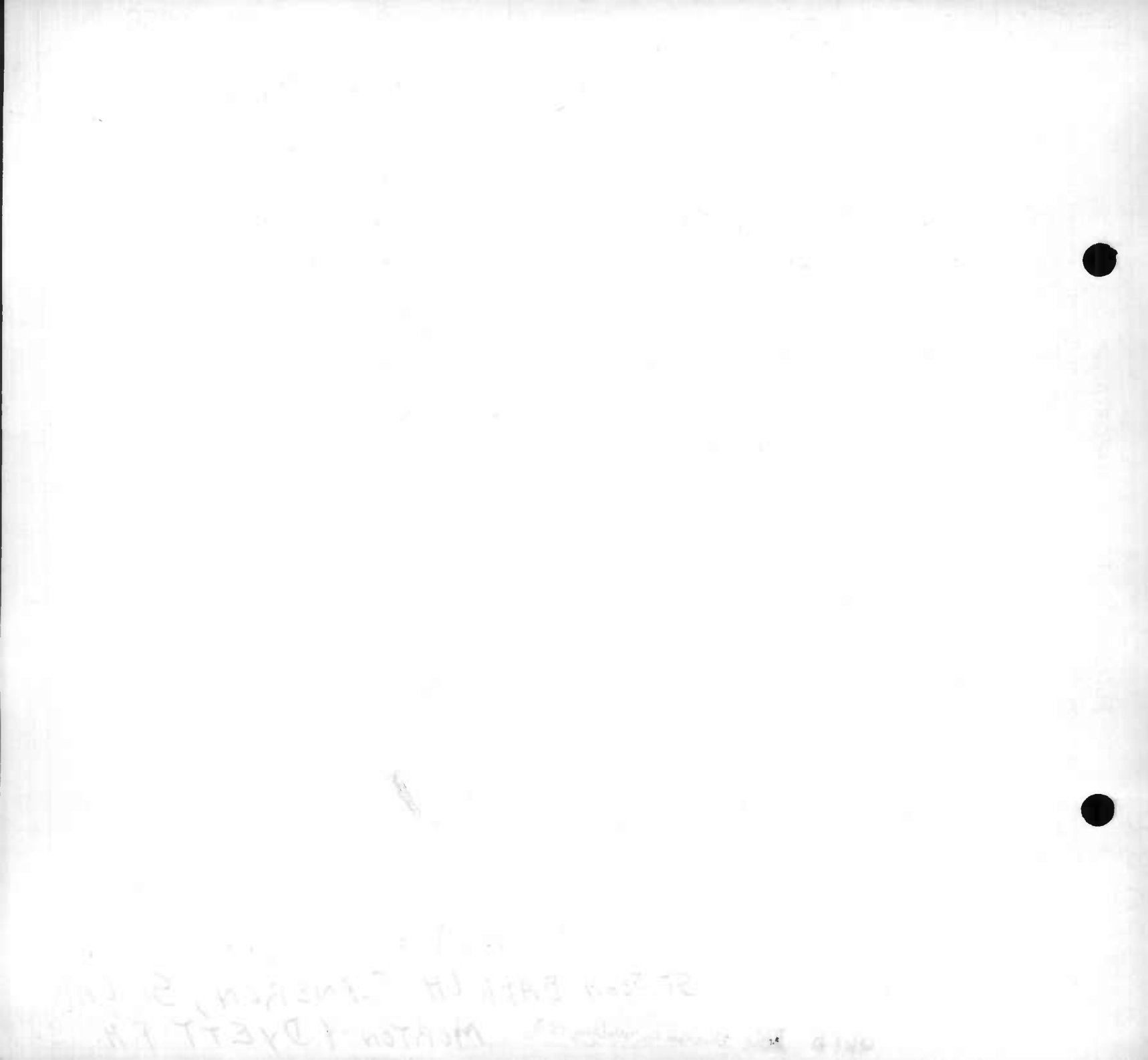
1000

1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		71 9256	
BIRTH NO. 71 9256				CERTIFICATE OF DEATH		REG. NO. 71 9256	
1. NAME OF DECEASED (Type or Print) <b>Rebecca Simmons</b>				2. DATE AND HOUR OF DEATH <b>SEPT. 30, 1971</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>A.A.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 LUTHERAN HOSPITAL</b>				C. CITY OR TOWN <b>SEVERNA PARK</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>Route 2, Box 26</b>			
5. SEX <b>Female</b>	6. RACE <b>Black</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-29-15</b>	9. AGE (in years last birthday) <b>55</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Orangeburg S.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Purvin Glover</b>			
14. MOTHER'S MAIDEN NAME <b>C. Glover</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>George W. Simmons</b>			
18. <b>174X I</b> CAUSE OF DEATH				ADDRESS <b>Severna Park Md. Rt 2 Box 26</b>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Peripheral Circulatory Failure</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Ca. Breast - metastasis</b>				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>7/31/71</b> 19__ to __ 19__ that (I) (we) last saw the deceased alive on <b>9/30/71</b> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Anjana Joshi</b> M.D.				23B. DATE SIGNED <b>9/30/71</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>ANJANA JOSHI</b> M.D.				23D. ADDRESS <b>LUTHERAN HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/30/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>ST JOHN BAPT. CH</b>		24D. LOCATION (City, town, or county) (State) <b>CAMERON, S. CAR.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>MORTON F. DYE</b>			
25D. ADDRESS <b>1011 E. H. ST.</b>							



**BALTIMORE CITY HEALTH DEPARTMENT**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **71 9257**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

**Sabastian Gonzales MILLAN**

2. DATE OF DEATH

Known ☒ Estimated ☐ Month 10 Day 2 Year 71 Hour 9:00 p. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

**35 Church Home & HOSPITAL**

3. DATE PRONOUNCED DEAD

Month 10 Day 2 Year 71 Hour 9:00 p. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Md. B. COUNTY **202**

6. SEX

male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

**JAN 20 1930**

10. AGE (In years last birthday)

**40**

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

**8 S. Ann Street**

11. BIRTHPLACE (State or foreign country)

**PUERTO RICO**

12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

13. FATHER'S NAME

**MARINOI MILLAN**

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**OPERATOR HEAVY EQUIPMENT CONSTRUCTION**

15. MOTHER'S MAIDEN NAME

**MARIA GONZALES**

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**YES KORAM**

17. SOCIAL SECURITY NO.

**581-68-7446**

18. INFORMANT

ADDRESS

**GERMAN FORES 1724 E BALTIMORE ST**

19.

**E 965X1**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Multiple gunshot wounds of chest and

(A) IMMEDIATE CAUSE abdomen

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

**2**

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

STREET

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

**8 S. Ann St. ) - street**

22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.)

**10 2 71 8:30**

22E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

**Subject shot during altercation.**

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

**Ronald N. Kornblum, M.D.**

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

**10/3/71**

24A. BURIAL CREMATION, REMOVAL (Specify)

**BURIAL**

24B. DATE

**OCT 8 1971**

24C. NAME of CEMETERY or CREMATORY

**YABUCA MUNICIPAL CEM.**

24D. LOCATION (City, town, or county) (State)

**YABUCA PUERTO RICO**

25A. DATE REC'D BY HEALTH DEPT.

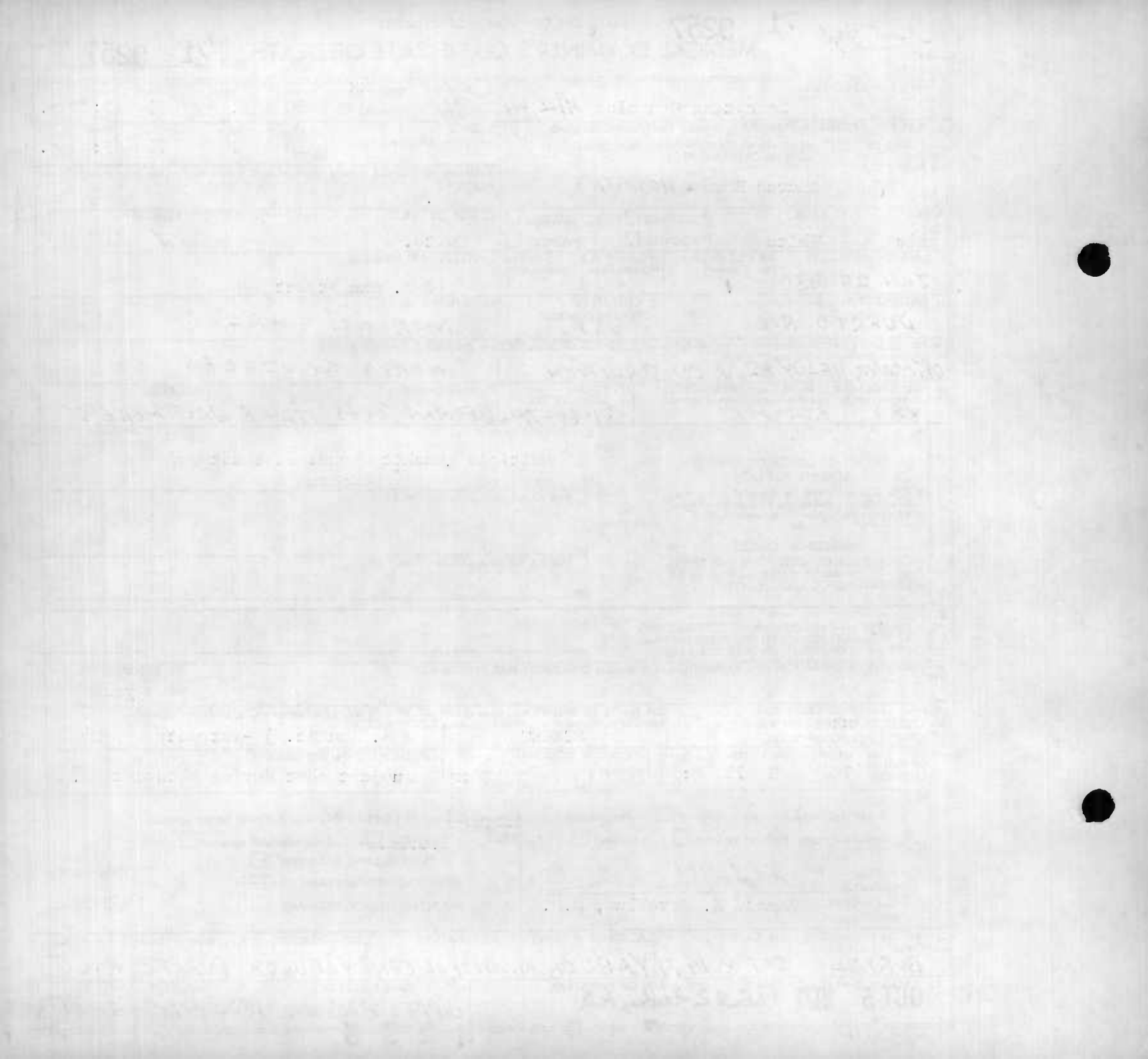
**OCT 5 1971**

25B. NAME OF REGISTRAR

**Robert E. Taylor, M.D.**

25C. FUNERAL DIRECTOR

**DIPPEL BROS INC 1800 E LOMBARDO ST**





BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9258	
1. NAME OF DECEASED (Type or Print) GILBERT Louis Rubin		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour 9 30 71 1:25 p. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 30 71 1:25 p. M.		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY BALTO 5300	
6. SEX male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE PHOENIX YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH MAY 21, 1944		10. AGE (In years lost birthday) 26 27		E. STREET AND NUMBER BOX 372 Blenheim Road	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JACK RUBIN	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		14B. KIND OF BUSINESS OR INDUSTRY RETAIL		15. MOTHER'S MAIDEN NAME SADIE BERMAN	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS MR. MARVIN DAHNE, 8905 MIDDLEBROOK CT. #21133	
19. E965X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Gunshot wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) BAR		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 842 W. Saratoga Street 1801	
22D. TIME OF INJURY (APPROX.) 9 30 71 1:00 p. M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject was shot by unknown assailant.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D. DATE SIGNED 10/1/71					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-3-71		24C. NAME of CEMETERY or CREMATORY SHAAREI ZION	
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. OCT 5 1971		25B. NAME OF REGISTRAR Robert E. Galy, M.D.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25D. ADDRESS			

2530

17

RECEIVED

JACK REIN

SABIE BROWN

100 N. W. 10th Ave. Miami, Fla.

Phone 1-2-1000

RECEIVED

10-3-31

10-3-31

10-3-31

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Nelson Fried		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour September 30, 71 2:40 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour September 30, 71 2:40 p.m.	
6. SEX male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 2-20-1912		10. AGE (In years lost birthday) 59	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <del>XXXXXXXXXX</del> FOREMAN		14B. KIND OF BUSINESS OR INDUSTRY PRINTING BUSINESS	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	
18. INFORMANT ADDRESS MRS. ROSE FRIED, 5419 PRICE AVENUE #21215		13. FATHER'S NAME JACOB FRIED	
15. MOTHER'S MAIDEN NAME LENA ?		19. CAUSE OF DEATH Hypertension and arteriosclerotic cardiovascular disease	
20. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-3-71	
24C. NAME of CEMETERY or CREMATORY RODFE ZEDEK		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	

5419 Price Ave

0220 H.

S-20071

9260

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71

9260

BIRTH NO.

1. NAME OF DECEASED (Type or Print) David Sacks		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 2 Year 71 Hour 7:30 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital		3. DATE PRONOUNCED DEAD Month 10 Day 2 Year 71 Hour 7:30 P.M.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Sept. 19, 1887		10. AGE (In years, lost birthday) 84	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		14B. KIND OF BUSINESS OR INDUSTRY Retail	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Army W. W. I.		17. SOCIAL SECURITY NO. 216-09-1293	
18. INFORMANT Mr. Charles Lasket		ADDRESS 3007 Garrison Blvd.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 1		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? Garrison Blvd. -76 ft. So. of Grantly		22F. HOW DID INJURY OCCUR? Subject pedestrian hit by auto.	
22D. TIME OF INJURY (APPROX.) Month 10 Day 2 Year 71 Hour 7:00 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 10/3/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/3/1971	
24C. NAME OF CEMETERY or CREMATORY Jewish War Veterans Memorial Cemetery, Baltimore, Maryland		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1971		25B. NAME OF REGISTRAR Robert E. Faber, M.D.	
25C. FUNERAL DIRECTOR Sol Levinson & Bros. 6010 Reisterstown Road.		ADDRESS	

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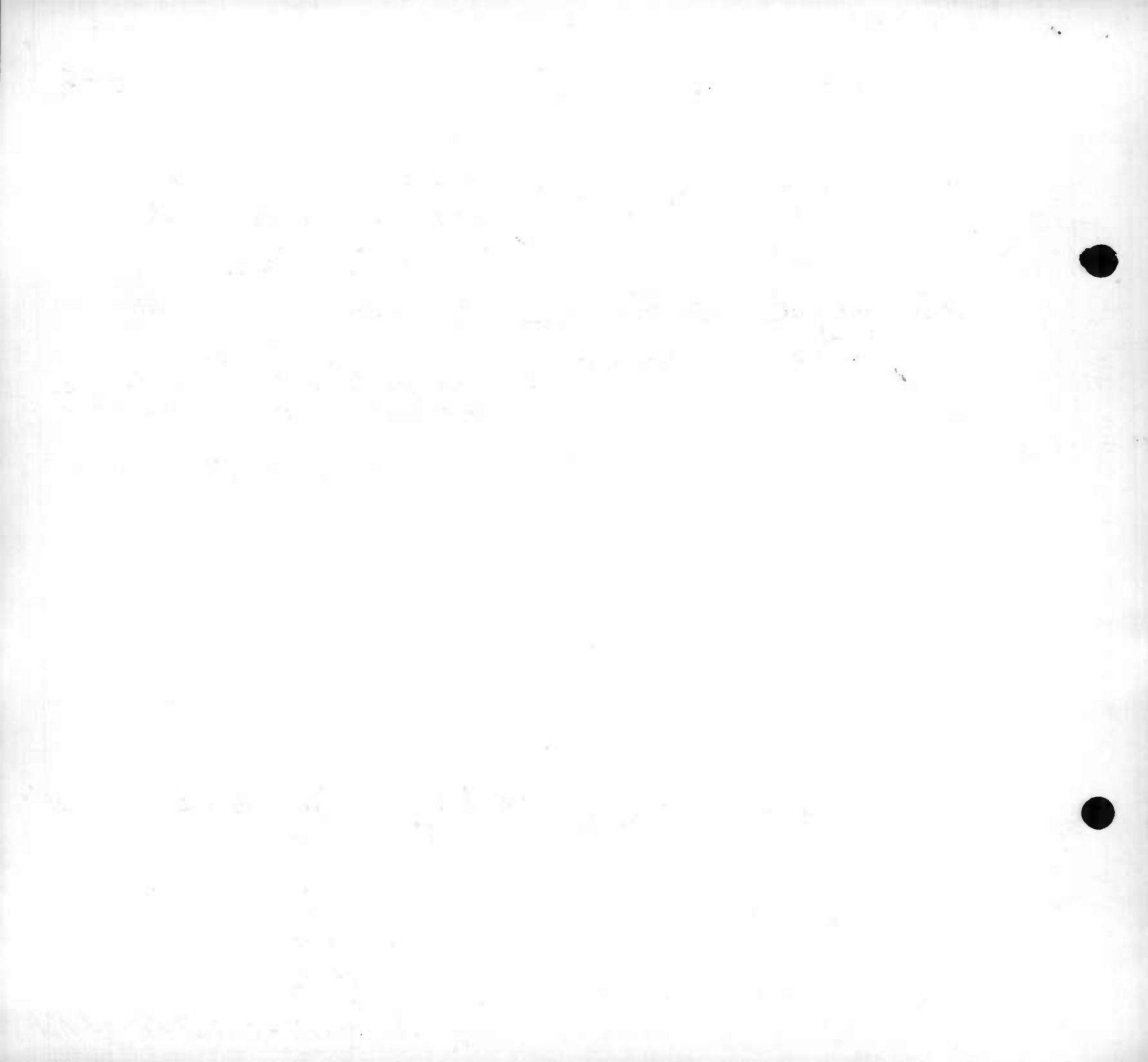
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9261</u>	
BIRTH NO. <u>N-253 71 9261</u>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>MAX Nochumowitz</u>		2. DATE AND HOUR OF DEATH <u>10-2-71</u> <u>645</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u>		A. STATE <u>MD</u>		B. COUNTY <u>2102</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1148 W Hamburg St</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/13/09</u>	9. AGE (in years last birthday) <u>62</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Alterations</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Mendel Nochumowitz</u>			
14. MOTHER'S MAIDEN NAME <u>Cecilia Scher</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>1-422-142</u>		17. INFORMANT <u>Mrs. Sara Timen - Same</u>			
18. <u>153.8</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Carcinoma of Colon</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <u>10/2/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/1/71</u> to <u>10/2/71</u> that (I) (we) last saw the deceased alive on <u>10/2/71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Julio V. Maggi</u>		23B. DATE SIGNED <u>10/2/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Julio V. Maggi</u>	
23D. ADDRESS <u>3001 S. Hanover St.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>10/3/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Charles Shalom</u>		24D. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor R.D.</u>		25C. FUNERAL DIRECTOR <u>Edgewood - Bros</u>	
25D. ADDRESS <u>6010 Rust Rd</u>					



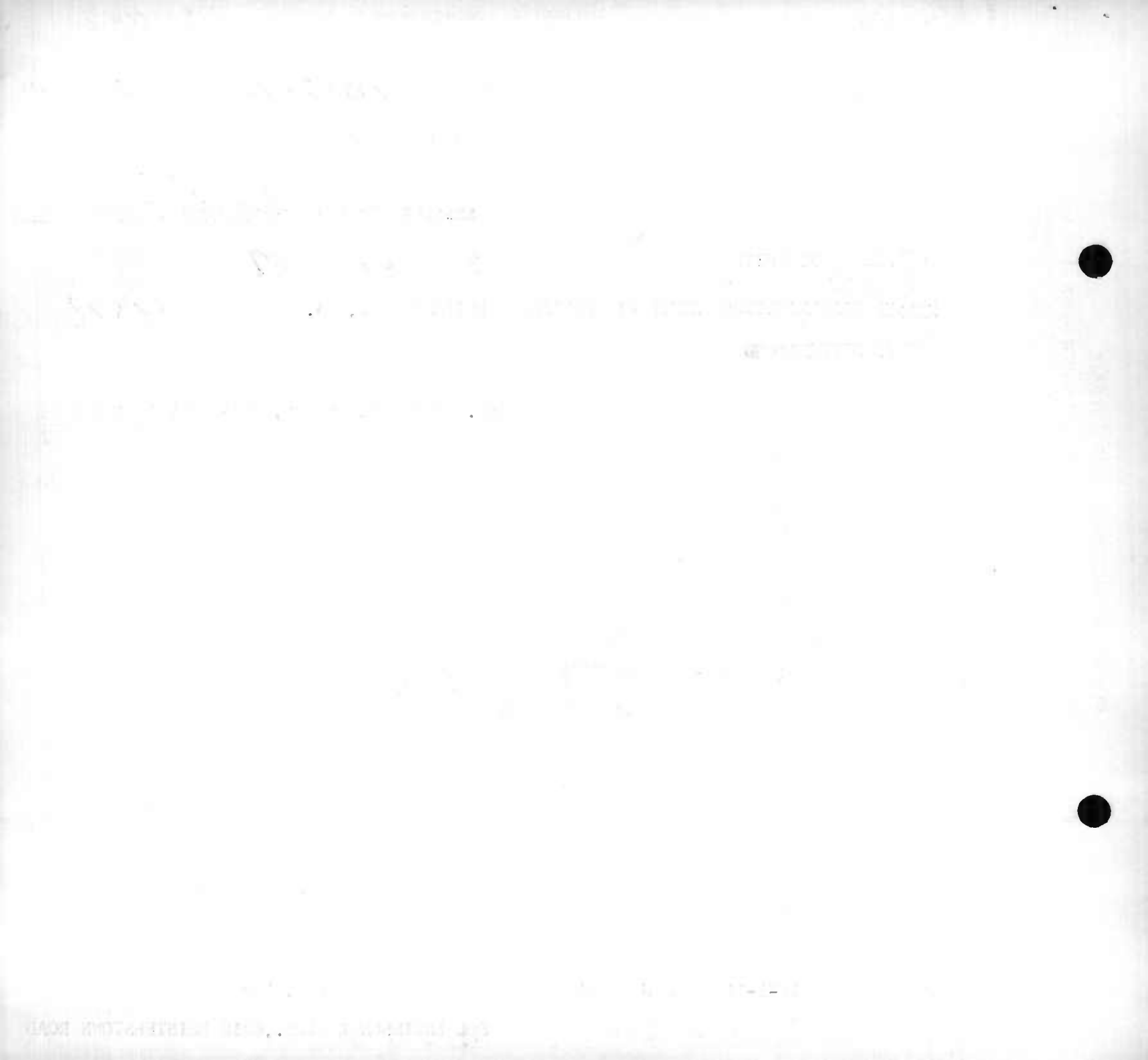




# FUNERAL DIRECTOR: IMPORTANT

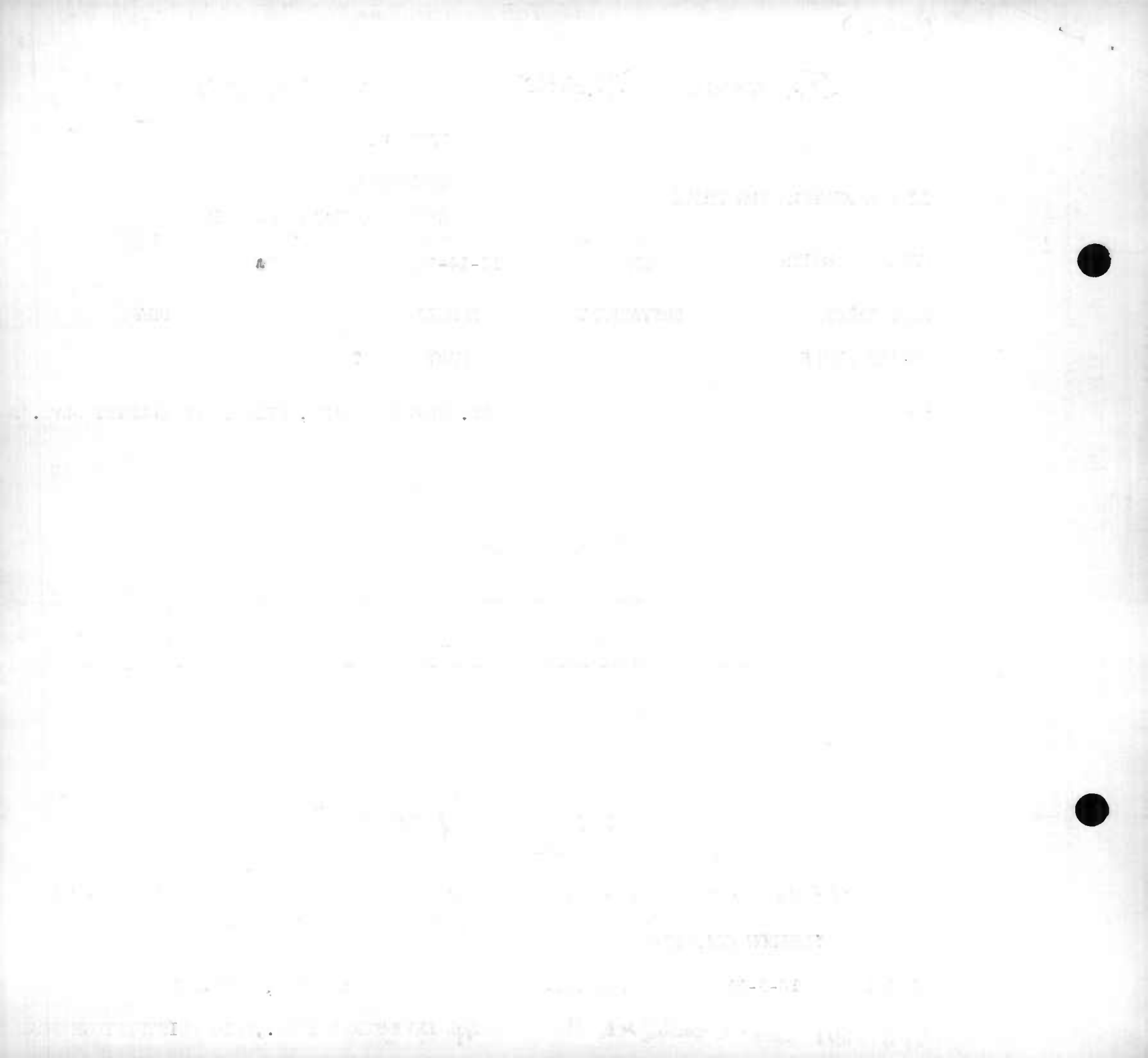
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-124 71 9262 ALBERT		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 9262 REG. NO.	
1. NAME OF DECEASED (Type or Print) ALBERT SPIEGELFORD			2. DATE AND HOUR OF DEATH 10-2-71 2:55 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL BALTO. 42			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY CITY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2811 BARTOL AVENUE XX		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-10-04	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXXXXXX AUDITOR		10B. KIND OF BUSINESS OR INDUSTRY STATE OF MARYLAND		11. BIRTHPLACE (State or foreign country) PHILADELPHIA, PA.	
13. FATHER'S NAME HYMAN SPIEGELFORD			12. CITIZEN OF WHAT COUNTRY USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. ROSE SPIEGELFORD, 2811 BARTOL AVENUE #9	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 486X I CIRCULATORY + RENAL FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: FAILURE (B) CEREBRAL FAILURE DUE TO, OR AS A CONSEQUENCE OF: (C) PNEUMONIA - RESPIRATORY FAILURE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-30-1971 to 10-2-1971 that (I) (we) last saw the deceased alive on 10-2-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE DENNIS GROLMAN			23B. DATE SIGNED 10-2-71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) DENNIS GROLMAN M.D.			23D. ADDRESS 40 SINAI HOSPITAL BALTO.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-3-71		24C. NAME OF CEMETERY or CREMATORY BNAI REUBEN	
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. OCT 5 1971			
25B. NAME OF REGISTRAR Robert E. Talbot, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-620		71 9263		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9263	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>SAMUEL MYERS</b>				2. DATE AND HOUR OF DEATH <b>OCT. 1, 1971 3:45 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b>				A. STATE <b>MARYLAND</b>		B. COUNTY <b>2740</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>5806 B WESTERN RUN DRIVE</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>5806 B WESTERN RUN DRIVE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-14-1890</b>	9. AGE (in years last birthday) <b>80</b>	10. If Under 1 Yr. Months Days II Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PROPRIETOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES MYERS</b>				14. MOTHER'S MAIDEN NAME <b>MARY ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. ELAINE MILLER, 5728 CROSS COUNTRY BLVD. #9</b>			
18. <b>153.8 I</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARCINOMA OF The Colon</b>		<b>2 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>July</b> 19 <b>64</b> to <b>Sept</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>Sept</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Sheldon Goldgeier</b>				23B. DATE SIGNED <b>Oct 1, 1971</b>			
23C. PHYSICIAN'S NAME (Type) <b>SHELDON GOLDGEIER</b>				23D. ADDRESS <b>848 W 36 St</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-3-71</b>		24C. NAME of CEMETERY or CREMATORY <b>SHAAREI TFILOH</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Faber, M.D.</b>		25C. FUNERAL DIRECTOR <b>SQL LEVINSON &amp; BROS.</b>		ADDRESS <b>6010 REISTERSTOWN ROAD</b>	



R-25071

9264

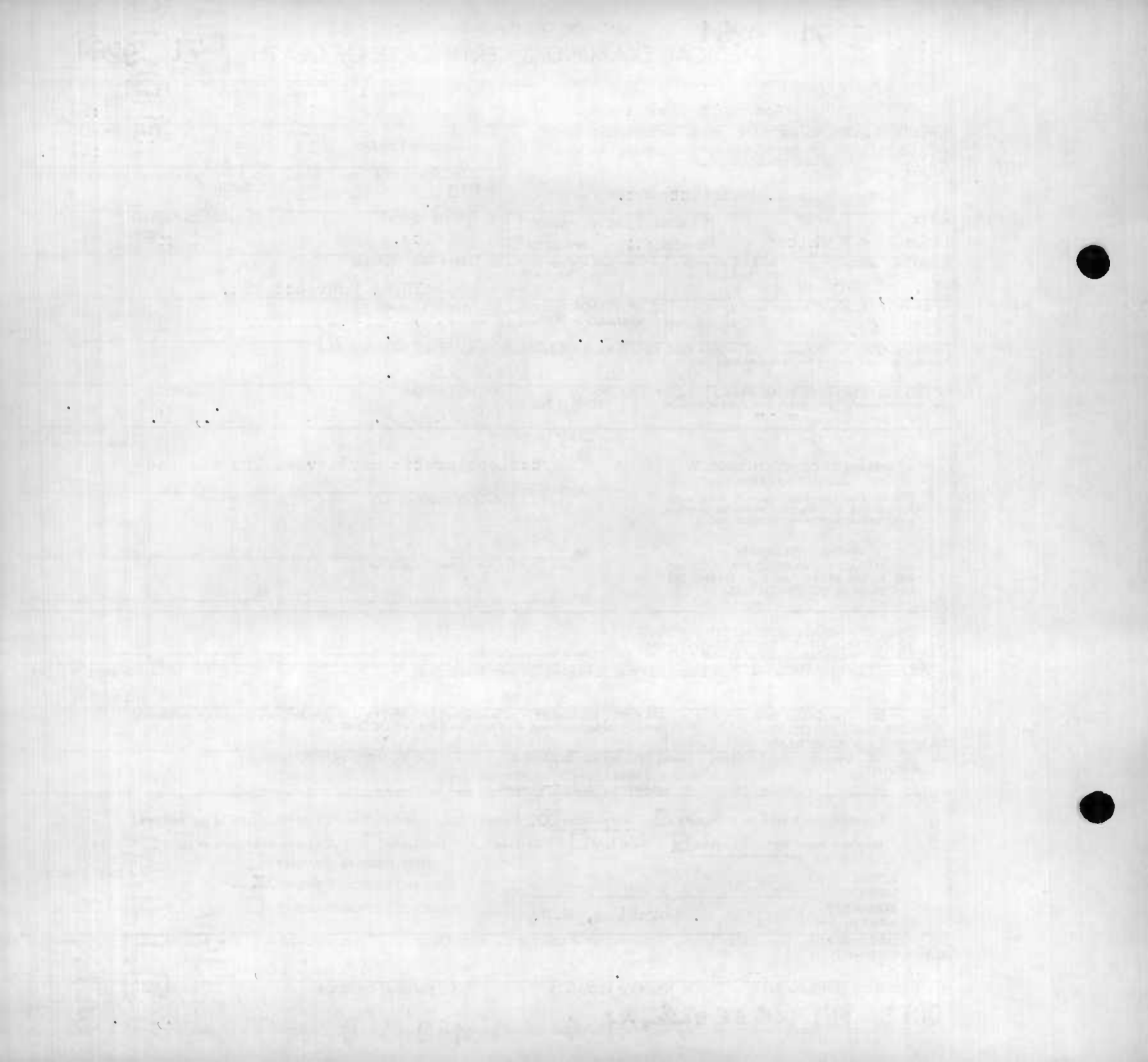
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9264

BIRTH NO.

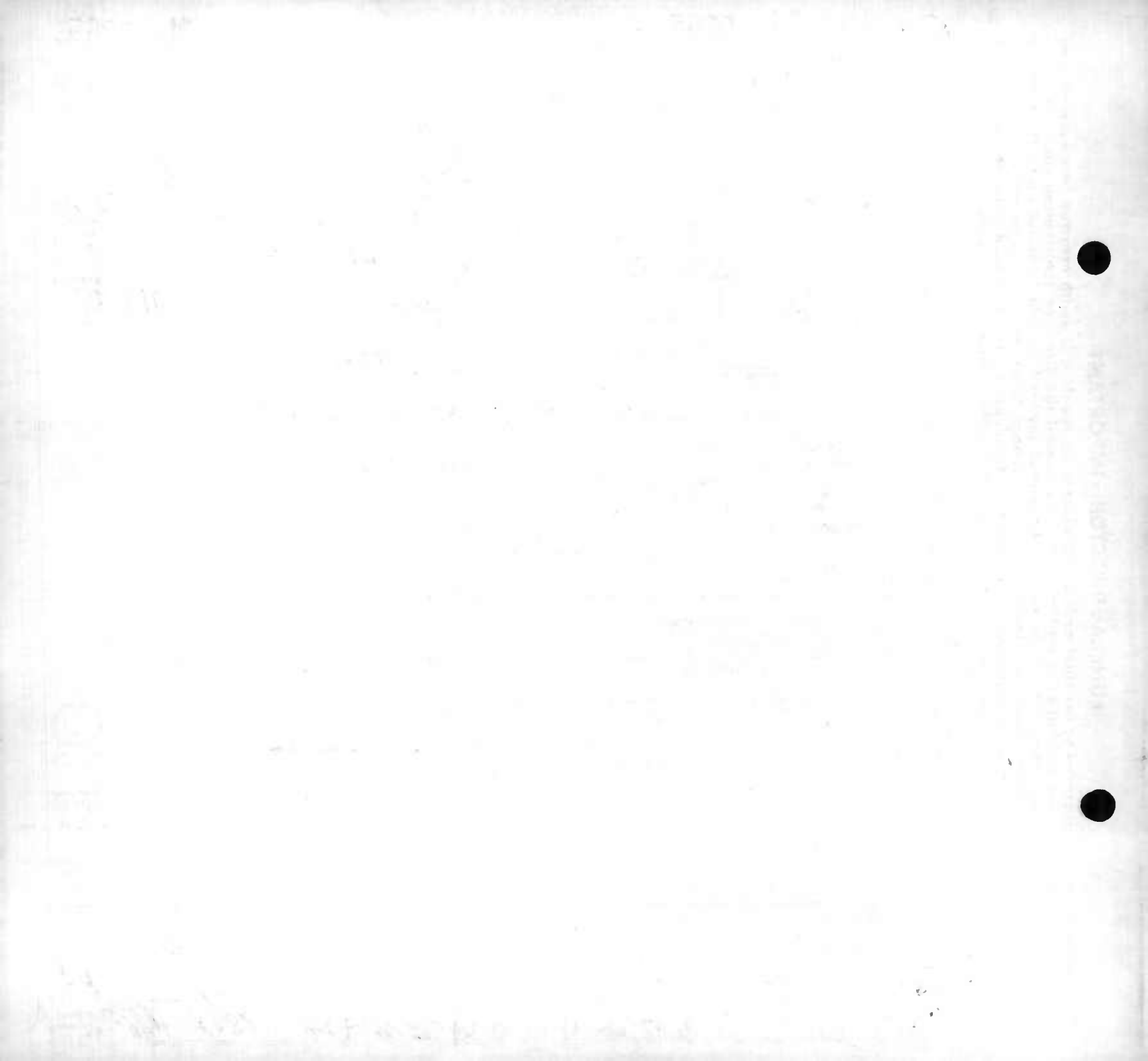
1. NAME OF DECEASED (Type or Print) Frederick Reign		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 3 Year 71 Hour 2:25 a. m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 35 E. Henrietta St.		3. DATE PRONOUNCED DEAD Month 10 Day 3 Year 71 Hour 2:25 a. m.	
5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Md. B. COUNTY 2302			
6. SEX male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH Dec. 3, 1893 77
10. AGE (In years lost birthday) 77		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lemuel B. Reign	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		15. MOTHER'S MAIDEN NAME Annie E. ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212 01 1428	
18. INFORMANT Charles F. Reign		ADDRESS 35 E. Henrietta St. Balto., Md. 21230	
19. CAUSE OF DEATH 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 10/3/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-7-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1971		25B. NAME OF REGISTRAR Robert E. Farber, R.D.	
25C. FUNERAL DIRECTOR 130 East Port Avenue No. 1111 Funeral Home Balto., Md. 21230			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620 71 9265		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9265	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOHN T. BURKE</b>		2. DATE AND HOUR OF DEATH <b>Oct. 3 1971 1:10 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2734</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINA Hospital</b>		C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>5625 Waltham Ave</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15 1916</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shear Man</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>BURKE</b>		14. MOTHER'S MAIDEN NAME <b>MARY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-10-6870A</b>		17. INFORMANT <b>John E Burke</b>	
				ADDRESS <b>Same</b>	
18. <b>202.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>METASTATIC LYMPHOMA</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Constrictive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years.</b> <b>?</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct. 3 1971</b> to <b>October 3 1971</b> that (I) (we) last saw the deceased alive on <b>October 3 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Juan L. Roque MD</b>		23B. DATE SIGNED <b>10/3/71</b>			
23C. PHYSICIAN'S NAME (Type) <b>JUAN L. ROQUE, MD</b>		23D. ADDRESS <b>SINA HOSPITAL BALTIMORE. 21215</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/6/71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Medow Ridge Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Dorsey MD</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1971</b>		25B. NAME OF REGISTRAR <b>Barbara J. [unclear]</b>		25C. FUNERAL DIRECTOR <b>G. F. [unclear]</b>	
				ADDRESS <b>8802 HARTFORD Rd</b>	

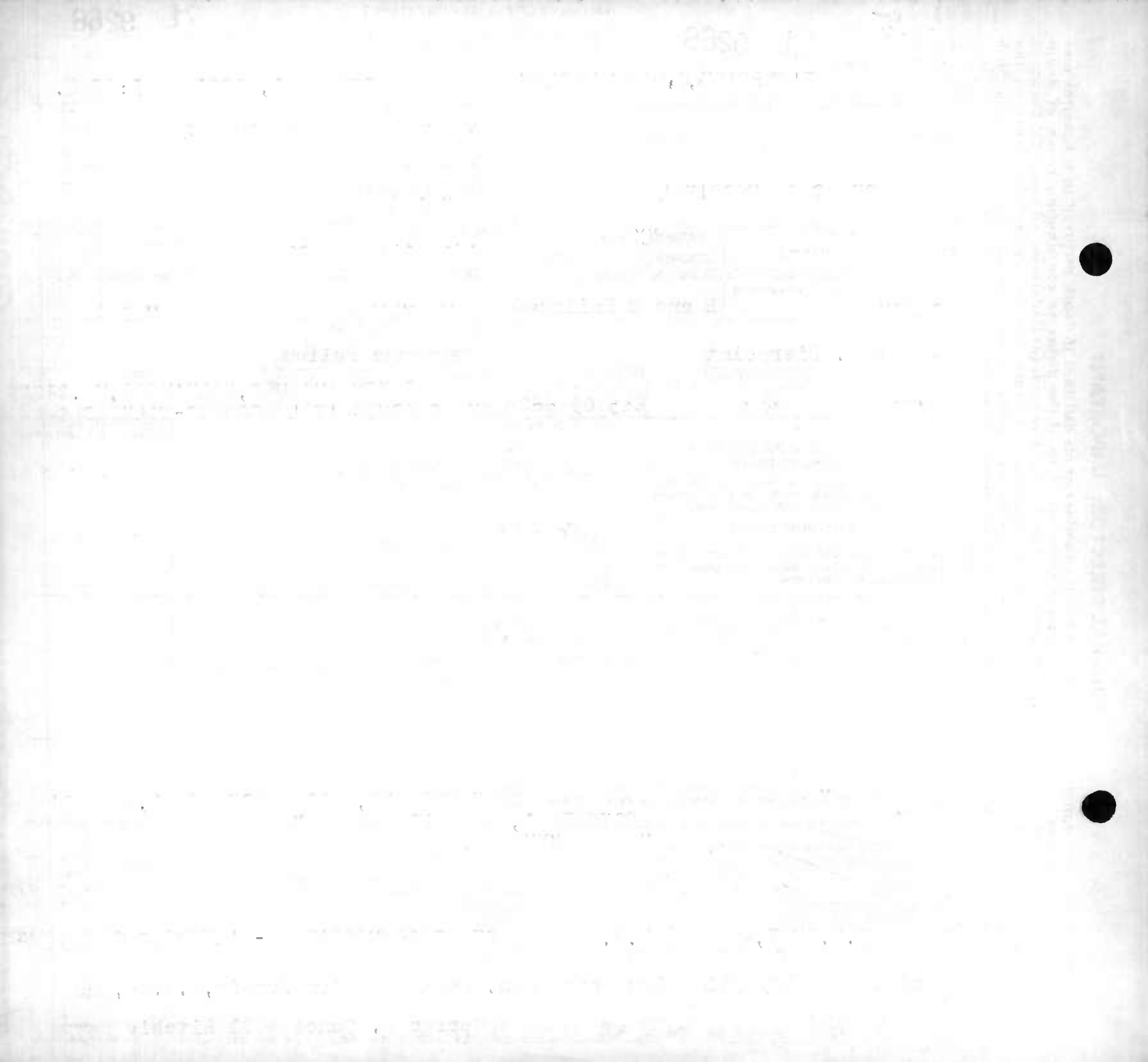




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		71 9266		71 9266	
BIRTH NO. <b>P-615</b>		71 9266		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>PIERPOINT, JR., JAMES WESLEY</b>			2. DATE AND HOUR OF DEATH <b>OCTOBER 1, 1971   3:00 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 ST AGNES HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>ANNE ARUNDEL</b> C. CITY OR TOWN <b>PASADENA</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>BOX 386</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>01/19/18</b>	9. AGE (In years last birthday) <b>53</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>B and O Railroad</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>James W. Pierpoint</b>			14. MOTHER'S MAIDEN NAME <b>Gertrude Fullum</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW 2</b>			16. SOCIAL SECURITY NO. <b>215-09-6625</b>		17. INFORMANT ADDRESS <b>CATON AVENUES, BALTIMORE, MD. 21229</b> <b>ST AGNES HOSPITAL RECORDS-WILKENS</b>
18. <b>436.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRO-VASCULAR ACCIDENT</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>GENERALIZED ATHEROSCLEROSIS</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>1 1/2 HRS</b> (B) <b>YEARS</b> (C) <b>—</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 HRS</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>NONE</b>					
19A. DATE OF OPERATION <b>D NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (1) (this hospital) attended the deceased from <b>SEPTEMBER 29, 1971</b> to <b>OCTOBER 1, 1971</b> that (1) (we) last saw the deceased alive on <b>OCTOBER 1, 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>F. N. BURT, M.D.</b>				23B. DATE SIGNED <b>1 OCTOBER 1971</b>	
23C. PHYSICIAN'S NAME (Type) <b>F. N. BURT, M.D.</b>		23D. ADDRESS <b>ST AGNES HOSPITAL - WILKENS &amp; CATON AVES</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/4/71</b>	24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Mem. Park</b>	24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, A.A. Co. Md</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1971</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>	25C. FUNERAL DIRECTOR <b>George J. Gonce</b>	ADDRESS <b>4001 Ritchie Hgwy</b>		



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

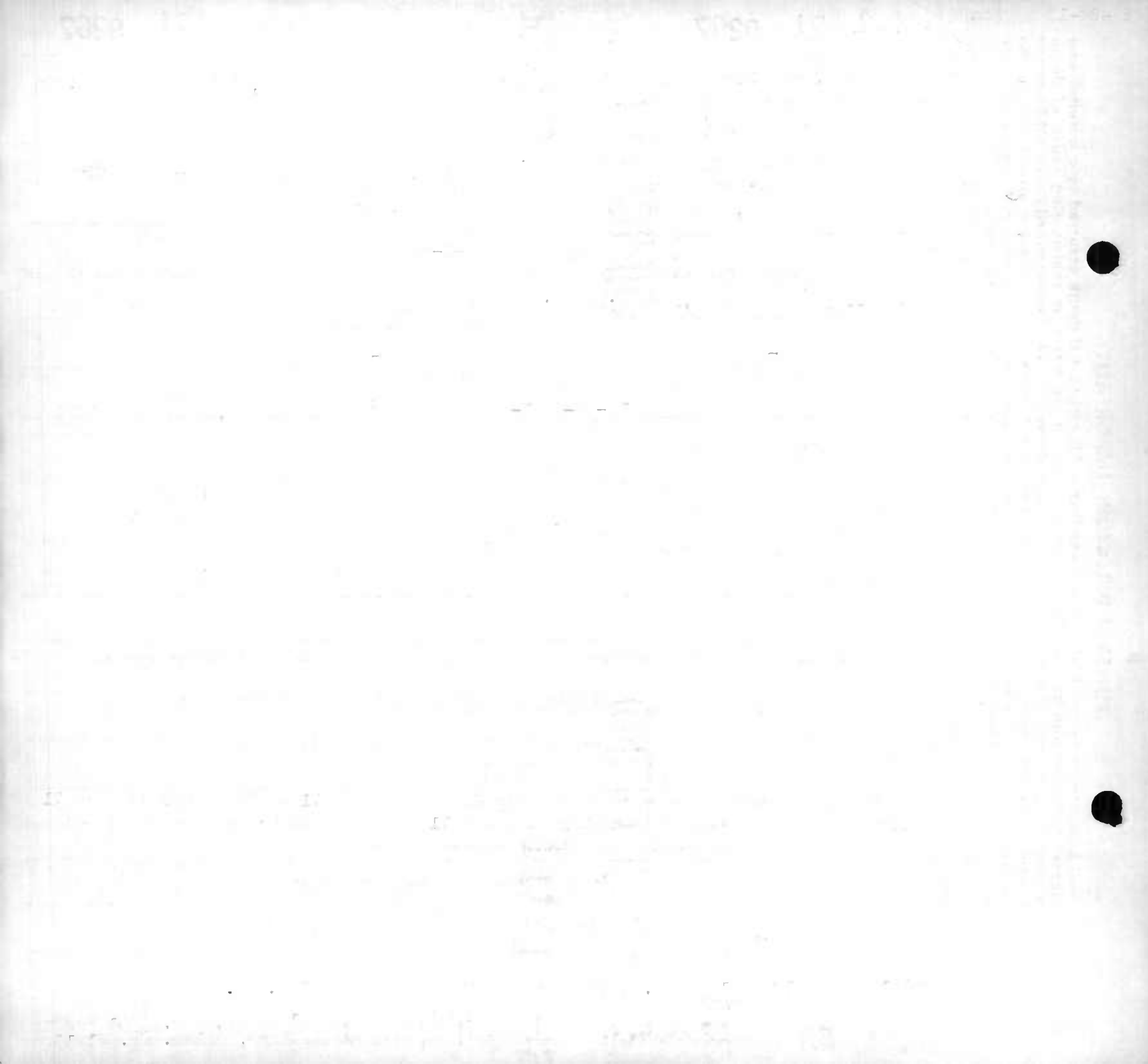
BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

71 9267

BIRTH NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
James Kucharski (AKA Stanislaus Kucharski)		September 30, 1971 12:00 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE Maryland B. COUNTY Harford County	
5. SEX Male		6. RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-1-87	
9. AGE (In years last birthday) 84		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Distiller		10B. KIND OF BUSINESS OR INDUSTRY Chem. Corp. Nat'l Distiller &	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME -		14. MOTHER'S MAIDEN NAME -	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-05-3951-1	
17. INFORMANT BCH RECORDS: 4940 Eastern Avenue Baltimore, Maryland 21224		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Renal failure C.H.F. Complete heart block > 3 mo. Respiratory failure > 3 mo. (B) DUE TO, OR AS A CONSEQUENCE OF: Anterior ischemic heart disease > 3 mo. (C) Benign prostatic hypertrophy > 3 mo.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR (if in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that <del>XX</del> (this hospital) attended the deceased from July 6 19 71 to September 30 19 71 that <del>XX</del> (we) last saw the deceased alive on September 30 19 71 and that in <del>XX</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>XX</del> (We) (did) (did not) view the body after death.			
23A. SIGNATURE Surat Sinasa, M.D.		23B. DATE SIGNED 9/30/71	
23C. PHYSICIAN'S NAME (Type) SURAT SINASA, M.D.		23D. ADDRESS Baltimore city Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/4/71	
24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1971		25B. NAME OF REGISTRAR Robert E. Talley, M.D.	
25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.		25D. ADDRESS 3331 Brehms Lane, Balto. Md. 21213	



1

P-456 71 9268

BALTIMORE CITY HEALTH DEPARTMENT

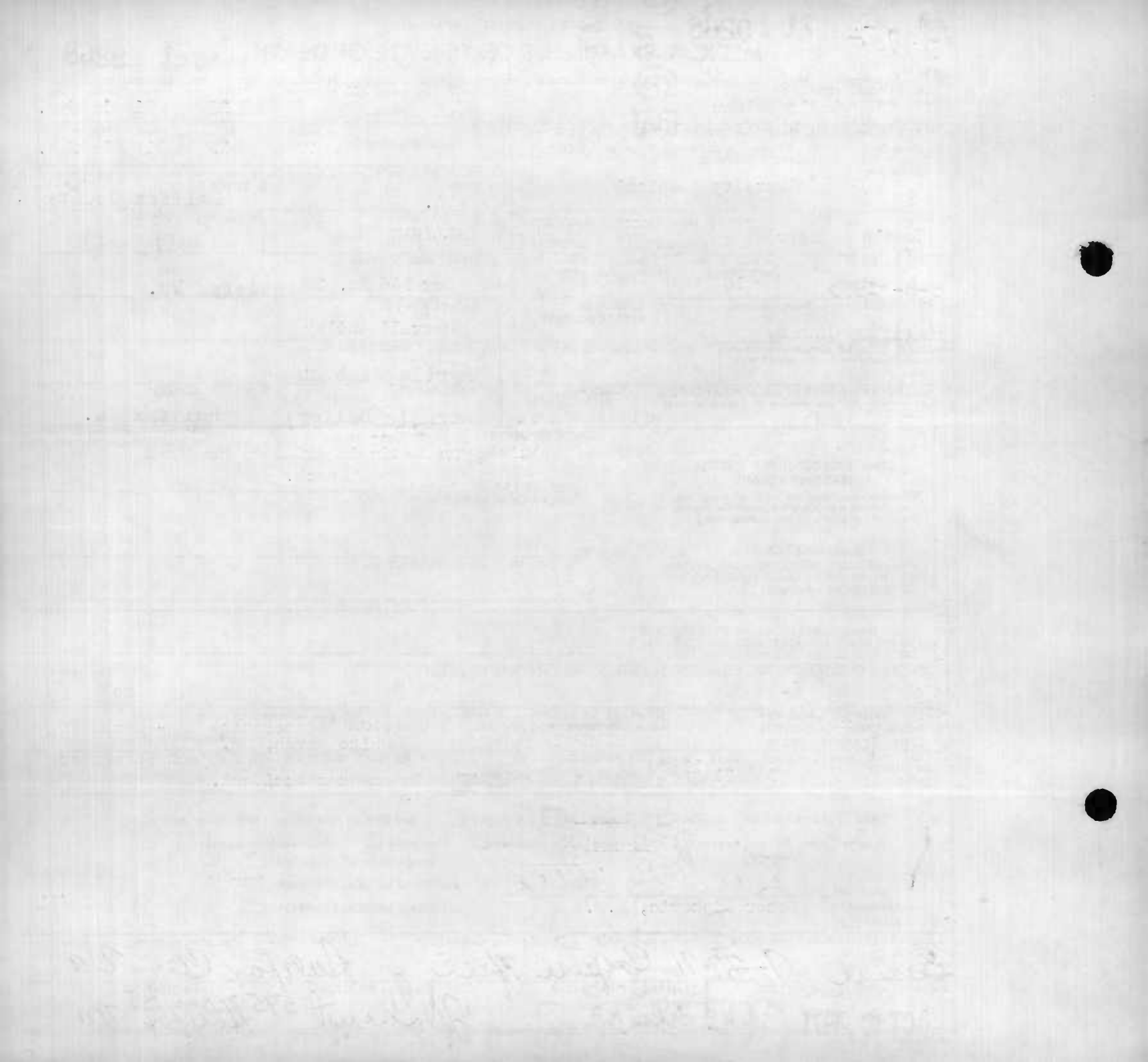
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9268

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sheila Palmer		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 9	Day 25	Year 71	Hour 1:45 p.m.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD		Month 9	Day 25	Year 71	Hour 1:45 p.m.
6. SEX female		7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN HALLIFAX		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 5-8-1953		10. AGE (In years lost birthday) 18	11. BIRTHPLACE (State or foreign country) Halifax County		E. STREET AND NUMBER Box 346 Rt. 2 Halifax Va.		
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Morrell Bailey		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
15. MOTHER'S MAIDEN NAME Myrtle Wimbush		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT Morell Bailey ADDRESS Halifax Va.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E 819.1 I DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Multiple traumatic injuries to head and neck. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HIGHWAY		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Interstate 95 - North of White Marsh, Md.			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 9 3 71 11:00 p.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject passenger in one car accident.			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/26/71							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-29-71		24C. NAME OF CEMETERY or CREMATORY Crystal Free		24D. LOCATION (City, town, or county) (State) Halifax Co. Va	
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR J.W. Garrett		ADDRESS 545 main st Halifax Va	

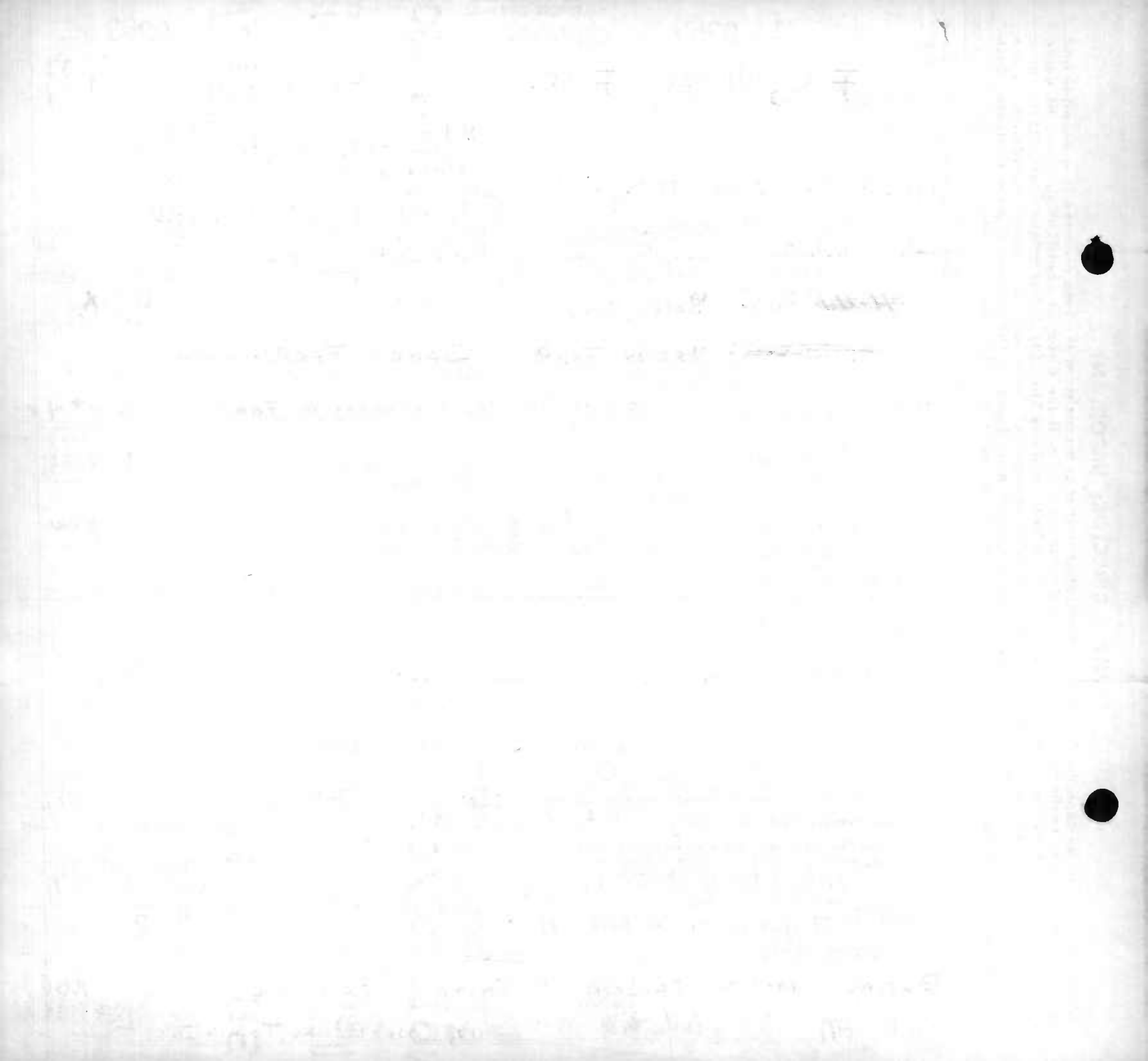
VS 151-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 9269	
7-630 71 9269		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>FORD, THOMAS. F. SR.</b>		2. DATE AND HOUR OF DEATH <b>Oct 4 1991 12:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>MD 21212</b>		5. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>7041 Heathfield Rd</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/18/07</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard Police</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balt. City</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>MARGARET MARION FORD</b>		14. MOTHER'S MAIDEN NAME <b>SARAH FARRINGTON</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-01-1905</b>		17. INFORMANT <b>Mrs. MARGARET M. FORD</b> ADDRESS <b>Sam 2 as # 4 E.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Lung cancer</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>3 years</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>Sept 22 1991</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cingulotomy for pain</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>INJURY OCCUR?</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>Sept 20 1991</b> to <b>Oct 4 1991</b>		that (I) (we) last saw the deceased alive on <b>Oct 4 1991</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>Teh-ching Wang</b>		23B. DATE SIGNED <b>Oct 9 1991</b>		23C. PHYSICIAN'S NAME (Type) <b>TEH-CHING WANG MD</b>	
23D. ADDRESS <b>Union Memorial Hosp 33rd &amp; Calvert street</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-7-91</b>	
24C. NAME of CEMETERY or CREMATORY <b>GARDENS OF FAITH</b>		24D. LOCATION <b>Baltimore Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1991</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor MD</b>		25C. FUNERAL DIRECTOR <b>Books Townson Inc</b>		ADDRESS <b>1050 York Rd Towson, Md. 21204</b>	



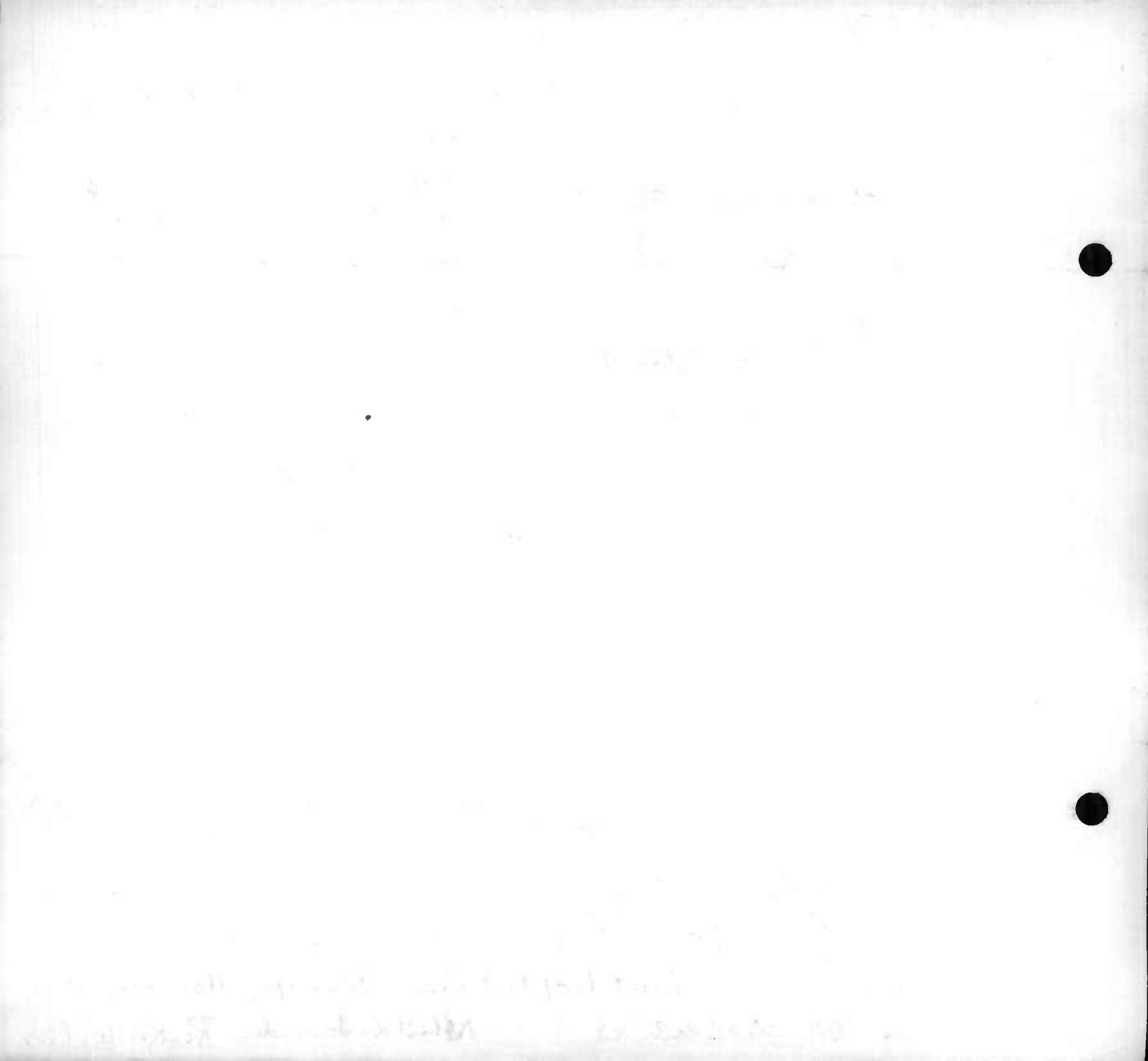


H-400 71 9270		BALTIMORE CITY HEALTH DEPARTMENT		71 9270	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
BIRTH NO.		REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>PRESTON Gary Hall</u>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 10	Day 2
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>31 Balto. City Hospital</u>		3. DATE PRONOUNCED DEAD Month 10		Day 2	Year 71
		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u>		B. COUNTY <u>2636</u>	
6. SEX male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH <u>JULY 10, 1953</u>		10. AGE (In years lost birthday) 18		E. STREET AND NUMBER 1311 Ballard Way	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ARNOLD C. HALL</u>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <u>WILMA J. WOLF</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		17. SOCIAL SECURITY NO. <u>262-56-6042</u>		18. INFORMANT <u>ARNOLD C. HALL - FATHER - 5 ABOVE</u>	
19. <u>304.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Narcotics Addiction</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <u>Ronald N. Kornblum</u> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED 10/2/71					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10/5/1971</u>		24C. NAME OF CEMETERY or CREMATORY <u>CREST LAWN</u>	
24D. LOCATION (City, town, or county) (State) <u>HOWARD CO. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 6 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Walter Dwyer Bradley, Bethesda, Md.</u>			

Letter from M.E.'s office 10-18-71 M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

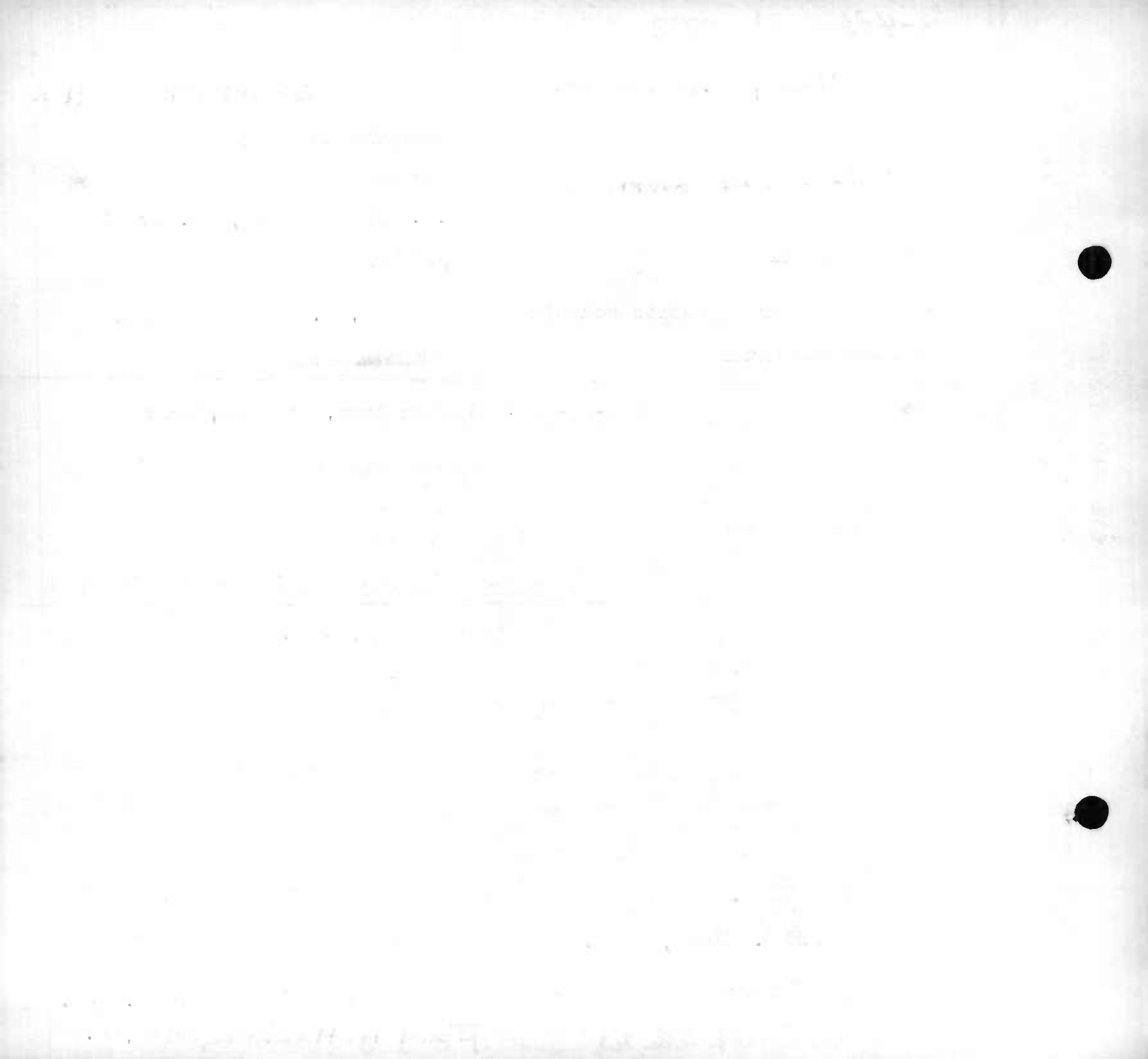
G-650 71 9271		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 9271 REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Sidney M. Green</i>			2. DATE AND HOUR OF DEATH <i>Sep 30, 1971 11 55 P M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>South Baltimore Gen. Hospital</i>			A. STATE <i>Md.</i> B. COUNTY <i>Howard</i>		
			C. CITY OR TOWN <i>Jessup</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <i>Box 8821 Mission Road</i>		
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-15-09</i>	9. AGE (In years lost birthday) <i>62</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Self</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md</i>	
13. FATHER'S NAME <i>Charles (dec)</i>			14. MOTHER'S MAIDEN NAME <i>Hattie Hall (dec)</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unknown</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Parents Chart.</i>	
18. <i>250.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Chr. renal failure</i> (B) <i>Diabetes Mellitus</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Arteriosclerotic heart disease</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Sep 7 1971</i> to <i>Sep 31 1971</i> that (I) (we) last saw the deceased alive on <i>Sep 31 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Yung Soo Paig</i>			23B. DATE SIGNED <i>9-30-71</i>		23C. PHYSICIAN'S NAME (Type) <i>Yung Soo Paig</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>			24B. DATE <i>10-5-71</i>		24C. NAME OF CEMETERY or CREMATORY <i>First Baptist Cem.</i>
24D. LOCATION (City, town, or county) (State) <i>Jessup, Howard, Md.</i>			25A. DATE REC'D BY HEALTH DEPT. <i>OCT 8 1971</i>		
25B. NAME OF REGISTRAR <i>Robert E. Fisher, Md.</i>			25C. FUNERAL DIRECTOR <i>Robert E. Snowden</i>		
			ADDRESS <i>Rockville, Md.</i>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

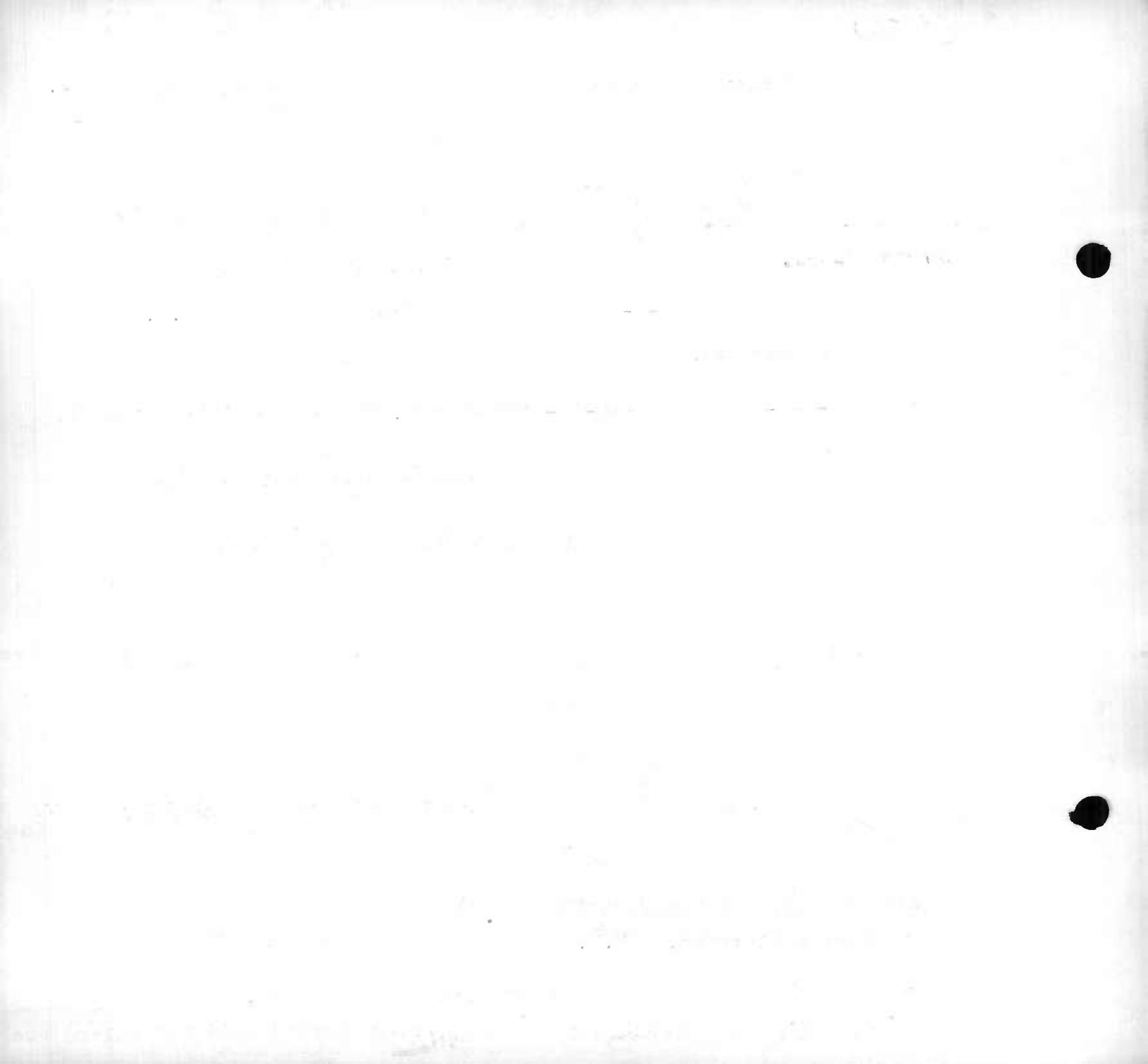
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9272</u>	
<div style="display: flex; justify-content: space-between;"> <span><u>S-436</u> <u>71</u> <u>9272</u></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>NANCY SHOWALTER</u>		2. DATE AND HOUR OF DEATH <u>30 SEPT. 1971</u> <u>11 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>			A. STATE <u>Pennsylvania</u> & COUNTY <u>York</u> <u>✓35</u> C. CITY OR TOWN <u>Airville</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>R.D. #2 Airville, Pa. 17302</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/17/04</u>	9. AGE (in years last birthday) <u>67</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Public schools</u>		11. BIRTHPLACE (State or foreign country) <u>Woodbine, Pa.</u>	
13. FATHER'S NAME <u>Joseph Showalter</u>			14. MOTHER'S MAIDEN NAME <u>Marian Ross</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>271-28-4147</u>		17. INFORMANT ADDRESS <u>William Ross, Midland, Texas</u>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>519.2 I</u> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>POLYARTERITIS NODOSA</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN</u> <u>3 DAYS</u> <u>3 DAYS</u> <u>1 1/2 YRS</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>28 Sept 1971</u> to <u>30 Sept 1971</u> that (I) (we) last saw the deceased alive on <u>30 Sept 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Keith L. Klein MD</u>				23B. DATE SIGNED <u>30 Sept 71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Keith L. Klein, M.D.</u>				23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-3-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Chanceford</u>	
24D. LOCATION (City, town, or county) (State) <u>Airville York Co. Pa.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 8 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>JOHN H. HARKINS, Delta, Pa.</u>			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9273</span>	
<b>C-560</b> <b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Thelma Mae Cumor</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">September 29, 1971 6 P. M.</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">00 3109 Crittenton Pl. Baltimore, Maryland 21211</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) <b>A. STATE</b> <span style="font-size: 1.2em;">Maryland</span> <b>B. COUNTY</b> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">3109 Crittenton Place 21211</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">White</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Aug 17, 1913</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">58 yrs.</span>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>			<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Howard Coleman</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Corbit</span>		
<b>15. Was Deceased Ever In U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">214-01-3328</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">John E. Cumor</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">3109 Crittenton Pl.</span>	
<b>18. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>I</b>  <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div style="width: 50%;"> <b>(A) IMMEDIATE CAUSE</b> <span style="font-size: 1.2em;">acute myocardial infarction</span>  <b>DUE TO, OR AS A CONSEQUENCE OF:</b>  <b>(B) antebiotic coronary Ar Dis.</b>  <b>DUE TO, OR AS A CONSEQUENCE OF:</b>  <b>(C)</b> </div> </div>					
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">Sept 27, 1971</span> <b>to</b> <span style="font-size: 1.2em;">Sept 29, 1971</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">Sept 27, 1971</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Edward H. Glassman, M.D.</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">9/30/71</span>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <span style="font-size: 1.2em;">Edward Glassman, M.D.</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">4037 Falls Road 21211</span>	
<b>24A. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">10/2/71</span>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Woodlawn Cemetery</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">OCT 6 1971</span> <b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span> <b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">DAN</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">Ovan Funeral Home 3818 Roland Ave</span>			

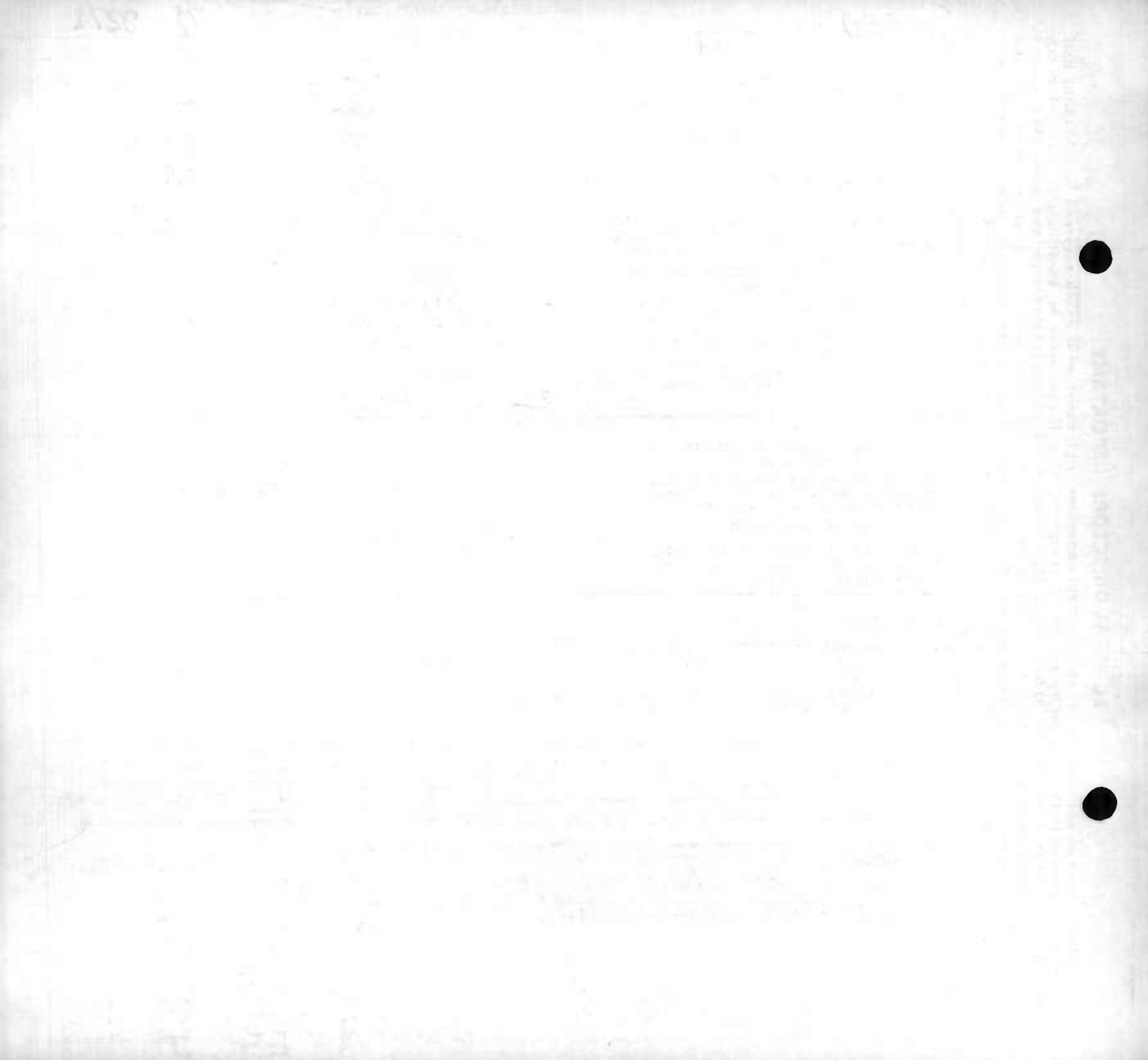




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9274</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">S-530 71 9274</span> <span style="font-size: 2em;">X</span> </div>					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">SMITH MAE</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">Oct 3, 1971 4:50 P.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">CHURCH HOME &amp; HOSPITAL 35</span>			A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">Howard</span>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <span style="font-size: 1.2em;">JESSUP</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">BOX 406 MAPLE AVE</span>		
5. SEX <span style="font-size: 1.2em;">FEMALE</span>	6. RACE <span style="font-size: 1.2em;">W A</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">1/30/91</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">80</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">NURSE</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">HOUSEWIFE</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">PAKISTAN</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>					
13. FATHER'S NAME <span style="font-size: 1.2em;">James Morrow</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">EMERY</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">201-10-2145</span>		17. INFORMANT <span style="font-size: 1.2em;">VERA POMPEY</span>	
				ADDRESS <span style="font-size: 1.2em;">SAME</span>	
18. <span style="font-size: 1.5em;">438.91</span> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <span style="font-size: 1.2em;">ELECTROLYTES IMBALANCE</span>					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">CARDIO-RESPIRATORY FAILURE</span>					
(B) <span style="font-size: 1.2em;">BRAIN EDEMA</span> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <span style="font-size: 1.2em;">INTESTINAL OBSTRUCTION</span>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">1/10/1/71</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">9/30</span> 19 <span style="font-size: 1.2em;">71</span> to <span style="font-size: 1.2em;">Oct 3</span> 19 <span style="font-size: 1.2em;">71</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Oct 3,</span> 19 <span style="font-size: 1.2em;">71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <span style="font-size: 1.2em;">R.C. Wang</span>					
23A. SIGNATURE <span style="font-size: 1.2em;">E. Borhani</span>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">ENAYATOLLAH BORHANI</span>		23D. ADDRESS <span style="font-size: 1.2em;">CHURCH HOME HOSPITAL</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">REMOVAL/BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">10/3/71</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">PAUL. NATIONAL CEMETERY</span>	
24D. LOCATION (City, town, or county) <span style="font-size: 1.2em;">LIMEKILN PIKE &amp; HAINES ST. PHILA. PA.</span>		24E. STATE <span style="font-size: 1.2em;">PA.</span>			
25A. DATE RECD BY HEALTH DEPT. <span style="font-size: 1.2em;">OCT 6 1971</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Barber, M.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">ULLRICH FUNERAL HOME 4210 BARBAR RD. 21206 BARNES F.D. 1907 N. 63rd PHILA. PA.</span>	

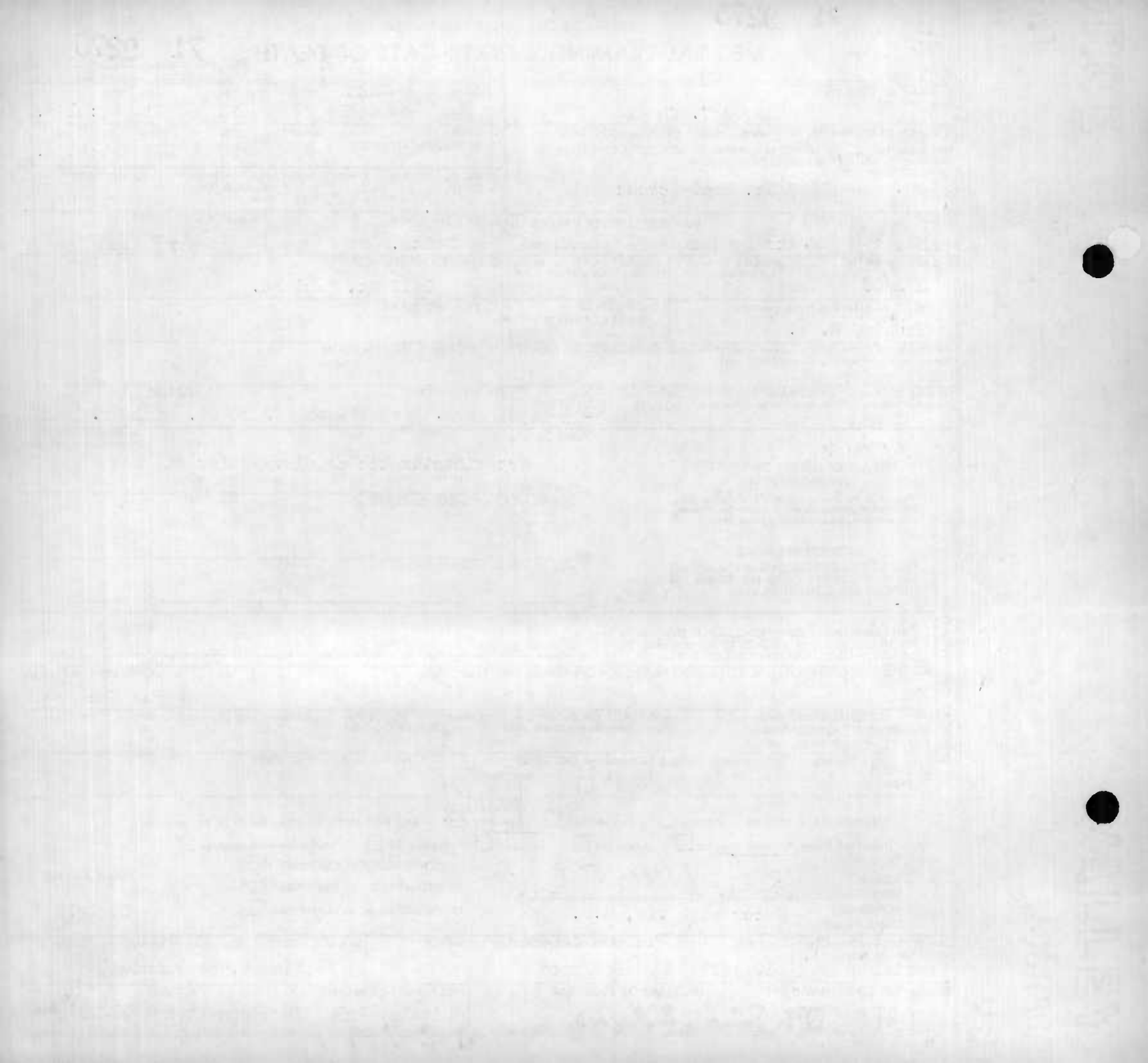


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

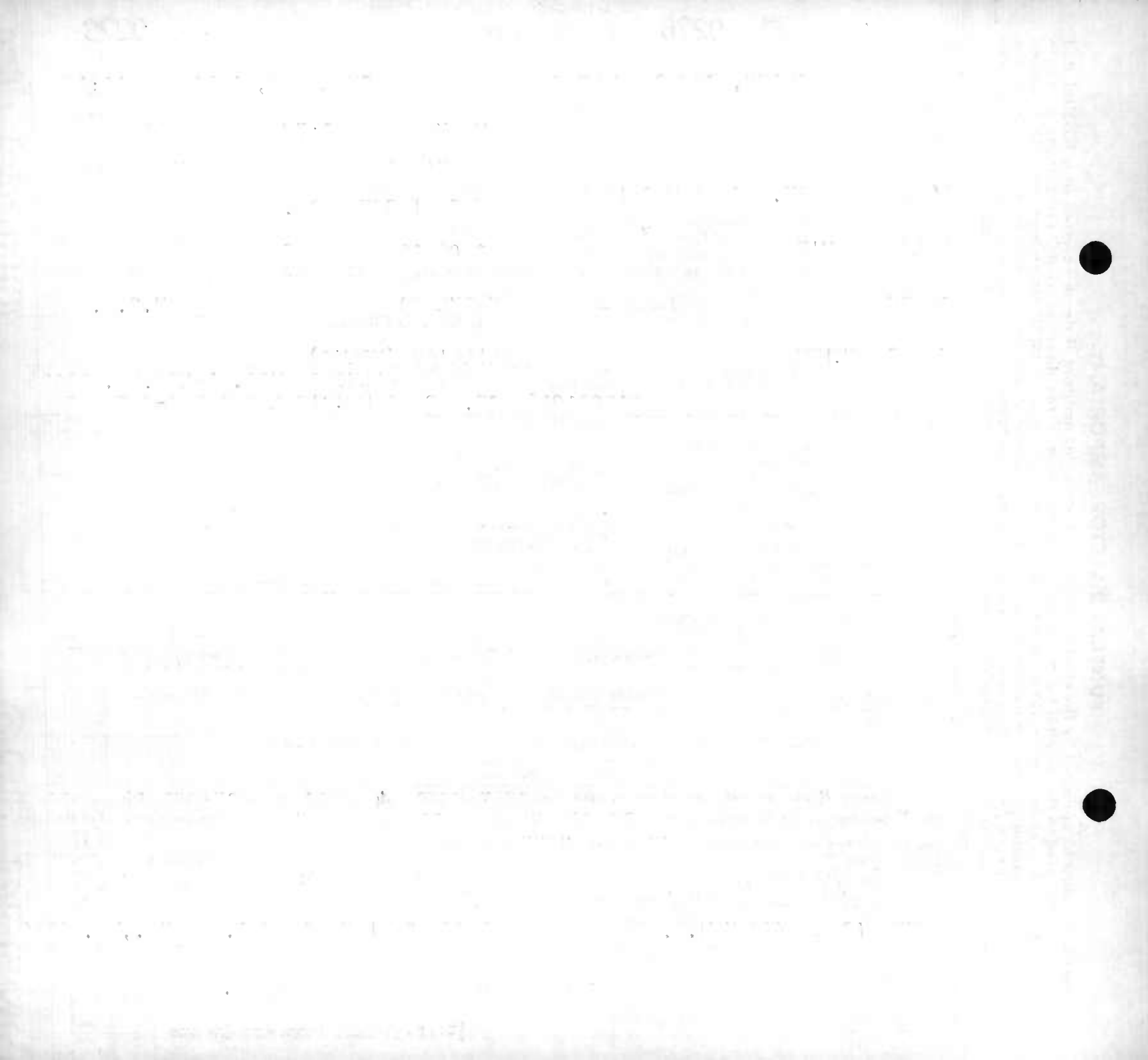
1. NAME OF DECEASED (Type or Print) Andrew T. Thomas		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 30 Year 71 Hour 1:42 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1617 St. Paul Street		3. DATE PRONOUNCED DEAD Month 9 Day 30 Year 71 Hour 1:42 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1205			
6. SEX male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.
9. DATE OF BIRTH 1/2/08		10. AGE (In years last birthday) 63	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) Tranis, N. Y.		12. CITIZEN OF WHAT COUNTRY? USA	E. STREET AND NUMBER 1617 St. Paul St.
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 063-16-2458	18. INFORMANT Mrs. Mary Wilson
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 1		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes (head only)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type): Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 10/1/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/3/71	24C. NAME OF CEMETERY or CREMATORY Parkwood
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue 21228



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 9276</u>	
BIRTH NO. <u>8-530 71 9276</u>				1. NAME OF DECEASED (Type or Print) <u>SMITH, GEORGE WALTER</u>		2. DATE AND HOUR OF DEATH <u>OCTOBER 4, 1971</u> <u>11:10P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>40 ST. AGNES HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> CITY <u>21229</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>505 KINGSTON RD.</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03 06 12</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months: Days: <u>59</u>	If Under 24 Hrs. Hours: Min. <u>59</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>WESTINGHOUSE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE SMITH</u>				14. MOTHER'S MAIDEN NAME <u>LILLIAN (HOLMS)</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212091016</u>		17. INFORMANT <u>WILKENS AVES. BALTO. MD. 21229</u> <u>ST. AGNES HOSPITAL RECORDS-CATON &amp;</u>			
18. <u>162.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Hoe manage</u> DUE TO, OR AS A CONSEQUENCE OF:  <u>4 Pneumoniae due to Metastatic Ca.</u> (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>10/8/71</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 04</u> 19 <u>71</u> to <u>OCTOBER 04</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>OCTOBER 04</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>THANICAL ANTONY M.D.</u>				23B. DATE SIGNED <u>10/4/71</u>		23C. PHYSICIAN'S NAME (Type) <u>THANICAL ANTONY M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/8/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 6 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Jones</u>		25C. FUNERAL DIRECTOR <u>Witzke, 7630 Edmondson Avenue</u>		ADDRESS	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9277

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

THOMAS MORANT

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

10

4

1971

11:15 a

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

1801

6. SEX

male

7. RACE

negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

9/1/31

10. AGE (In years  
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

936 W. Saratoga St.

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Clifton Morant

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

laborer

15. MOTHER'S MAIDEN NAME

Geneva Graham

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)

yes

Korean

17. SOCIAL SECURITY NO.

250-95-1443

18. INFORMANT

Mrs Geneva Morant, same

ADDRESS

19. 1571.8

CAUSE OF DEATH

Fatty metamorphosis of liver

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10-4-71

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10/10/71

24C. NAME OF CEMETERY or CREMATORY

Florence S

24D. LOCATION (City, town, or county)

South Carolina

(State)

25A. DATE REC'D BY HEALTH DEPT.

OCT 8 1971

25B. NAME OF REGISTRAR

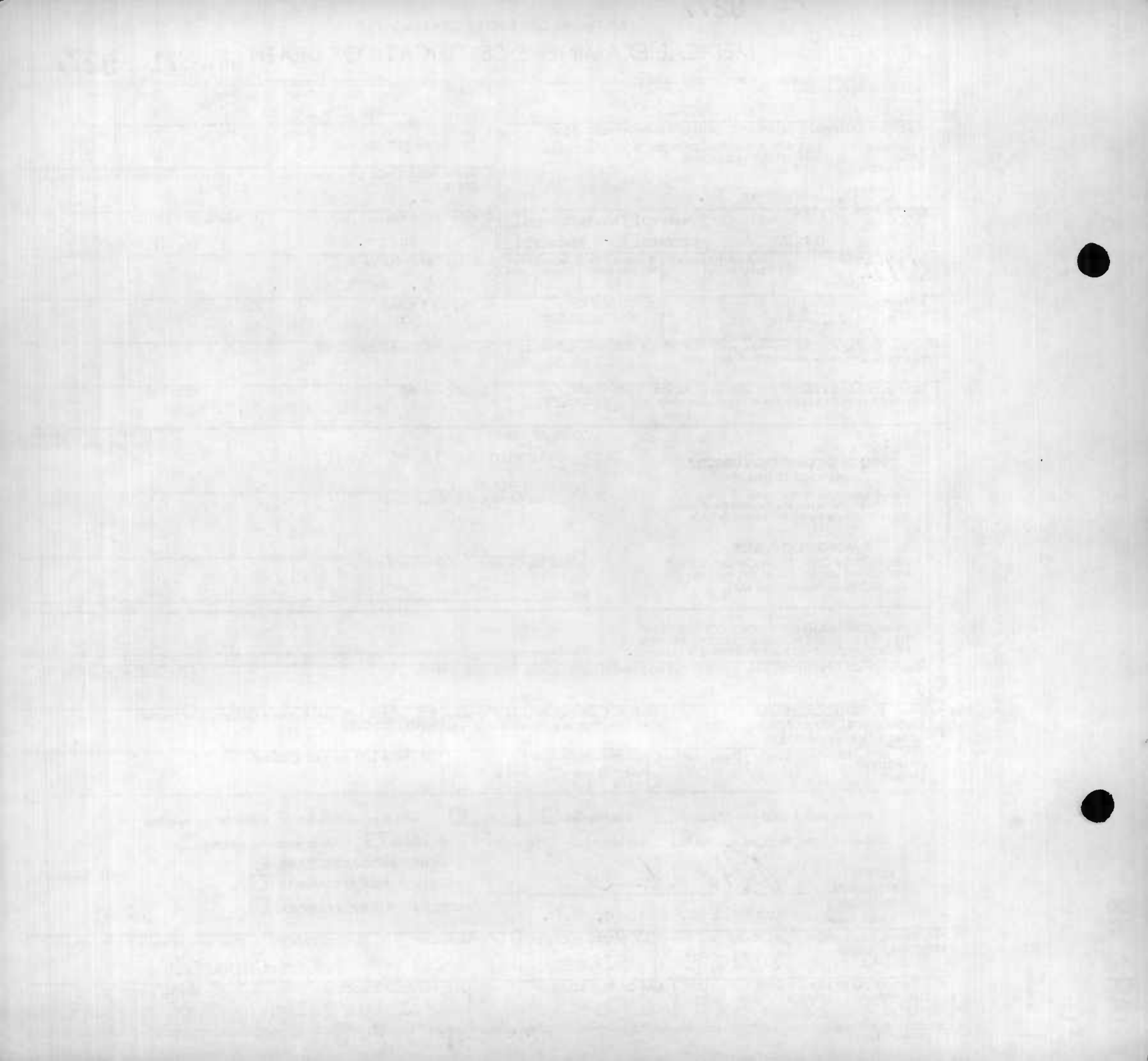
Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W

ADDRESS

North Ave

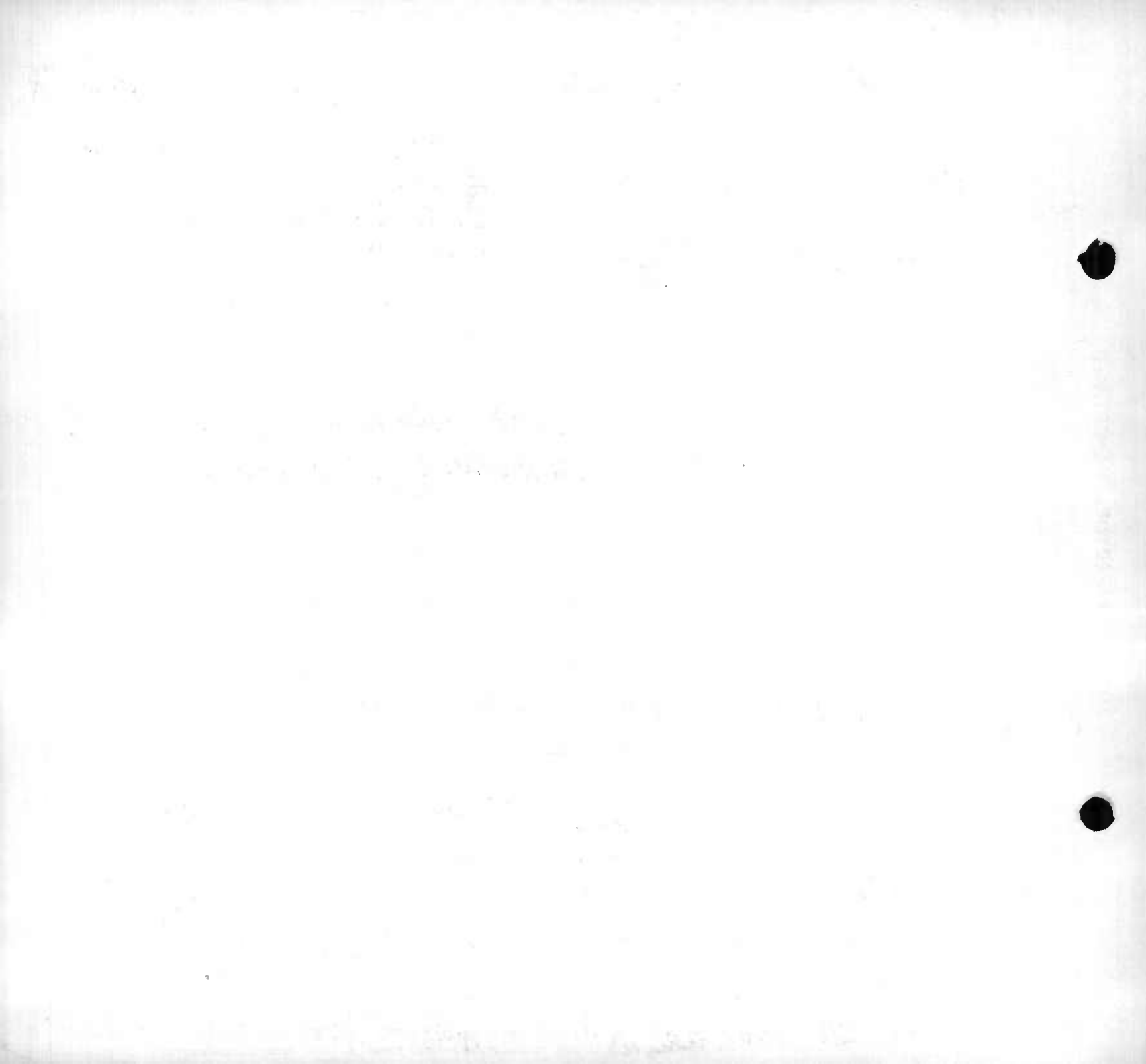




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

4-340 71 9278		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Hudley Maria</i>		2. DATE AND HOUR OF DEATH <i>10/4/71 8:00 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1403</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Granada Nursing Home</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>2131 McCulloh St</i>			
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/29/83</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <i>88</i>
11. BIRTHPLACE (State or foreign country) <i>Westmorland County Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Granada Nursing Home</i>
18. <i>4/12/3 I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Arterio Sclerotic Heart Disease</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		ADDRESS <i>4017 N. Fort Ave</i>	
MEDICAL CERTIFICATION			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/4/70</i> 19 to <i>10/4/71</i> 19 that (I) (we) last saw the deceased alive on <i>10/4/71</i> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Harris</i>		23B. DATE SIGNED <i>10/4/71</i>	
23C. PHYSICIAN'S NAME (Type) <i>Harris</i>		23D. ADDRESS <i>1801 Greenway Rd.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <i>10/8/71</i>	24C. NAME of CEMETERY or CREMATORY <i>Mt Calvary Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>A A County Md</i>
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 8 1971</i>	25B. NAME OF REGISTRAR <i>Robert E. J. ...</i>	25C. FUNERAL DIRECTOR <i>Amolphus Halstead</i>	ADDRESS <i>1206 W North A e</i>



ADDRESS

Letter from M.E.'s office 10-27-71 M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

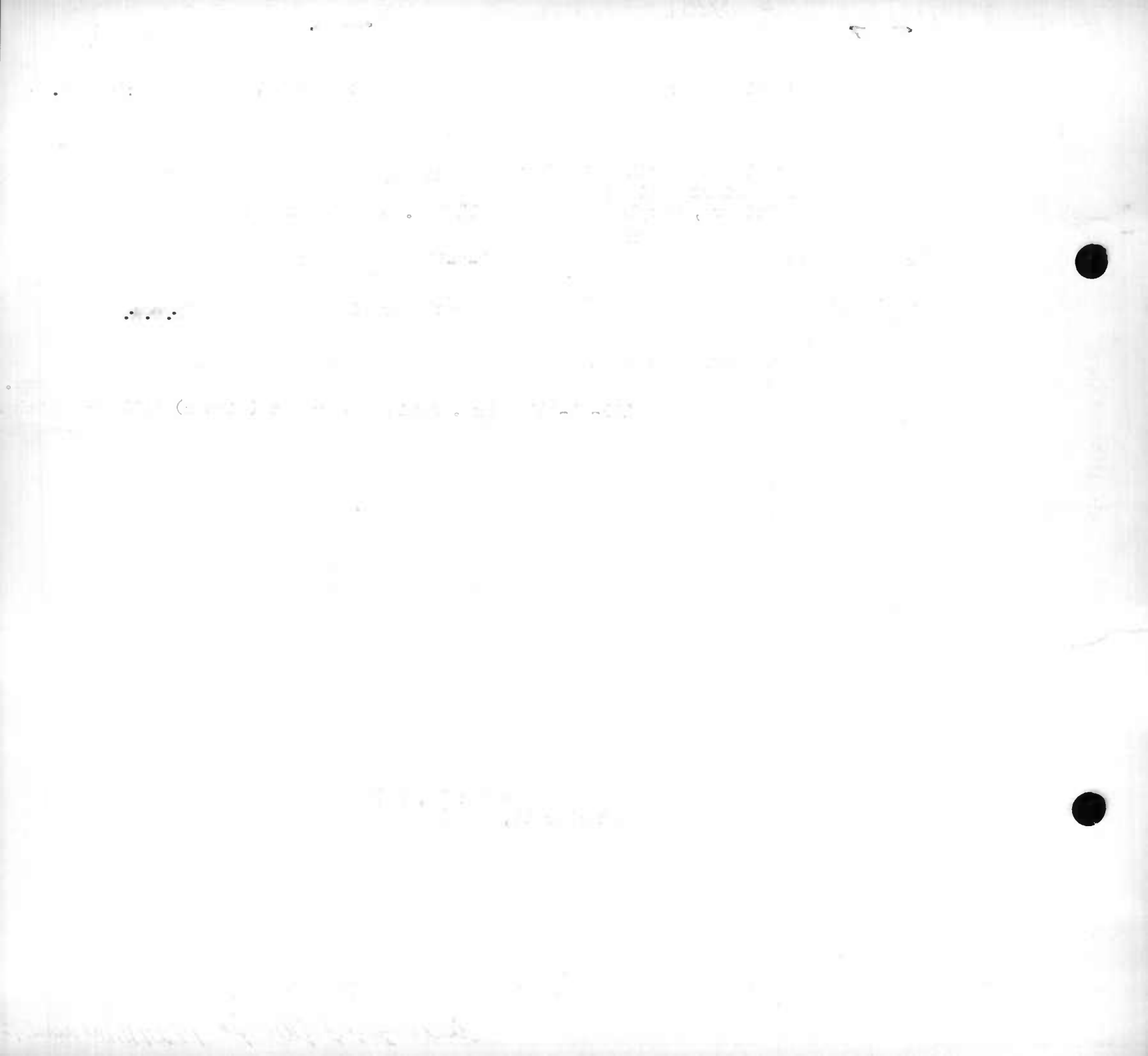
R-163 71 9280		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9280	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROBERTS HERMAN.</b>		2. DATE AND HOUR OF DEATH <b>October 4 1971 10<sup>10</sup> PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2788</b>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION, (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Sinai Hospital of Baltimore Inc, Belvedere Ave. at Greenspring.</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		8. DATE OF BIRTH <b>11/29/1900</b>	
13. FATHER'S NAME <b>Augustus Roberts</b>		14. MOTHER'S MAIDEN NAME <b>Rosie Matthis</b>		9. AGE (in years last birthday) <b>70</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <b>D. L. Moore, Texas</b>	
17. INFORMANT <b>Worthey Hays</b>		ADDRESS <b>809 N. Monroe ST.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
18. <b>150X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Acute respiratory insufficiency</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>St. after esophagectomy because</b>			
		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>of ca of esophagus</b>			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ca of esophagus</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/13/1971</b> 19 <b>71</b> to <b>10/4</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>October 4</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Kalisty</b>		23B. DATE SIGNED <b>10/4/1971</b>		23C. PHYSICIAN'S NAME (Type) <b>ZVI KALISTY</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-8-71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MT. Calvary Cem.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 8 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, Jr.</b>		25C. FUNERAL DIRECTOR <b>Henry G. Wilson</b>	
24D. LOCATION <b>Brooklyn Md.</b>		25D. ADDRESS <b>1000 Brantley Ave</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-536		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9281	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Calvin Anderson		2. DATE AND HOUR OF DEATH September 27, 1971 7:30 p. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital Complex 2600 Librty Heights Baltimore, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1601		C. CITY OR TOWN Baltimore	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1201 W. Lanvale Street			
5. SEX Male	6. RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-6-11	9. AGE (in years last birthday) 60	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Anderson		14. MOTHER'S MAIDEN NAME Alice Gordon	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-01-1414		17. INFORMANT Mrs. Annie Lee Bryant (Sister)	
ADDRESS 3723 Gwynn Oak Ave.		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE Hemorrhagic Shock		(B) GI bleeding		(C) Malignancy of the Mediastinum	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 29, 1971 to September 27, 1971 and that (I) (we) last saw the deceased alive on September 27, 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Webster Sewell M.D.		23B. DATE SIGNED 28 Sept 71		23C. PHYSICIAN'S NAME (Type) WEBSTER SEWELL M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/2/71		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial	
24D. LOCATION Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 6 1971		25B. NAME OF REGISTRAR R. E. Felt	
25C. FUNERAL DIRECTOR William F. Phillips		25D. ADDRESS 1727 N. Meade St.			





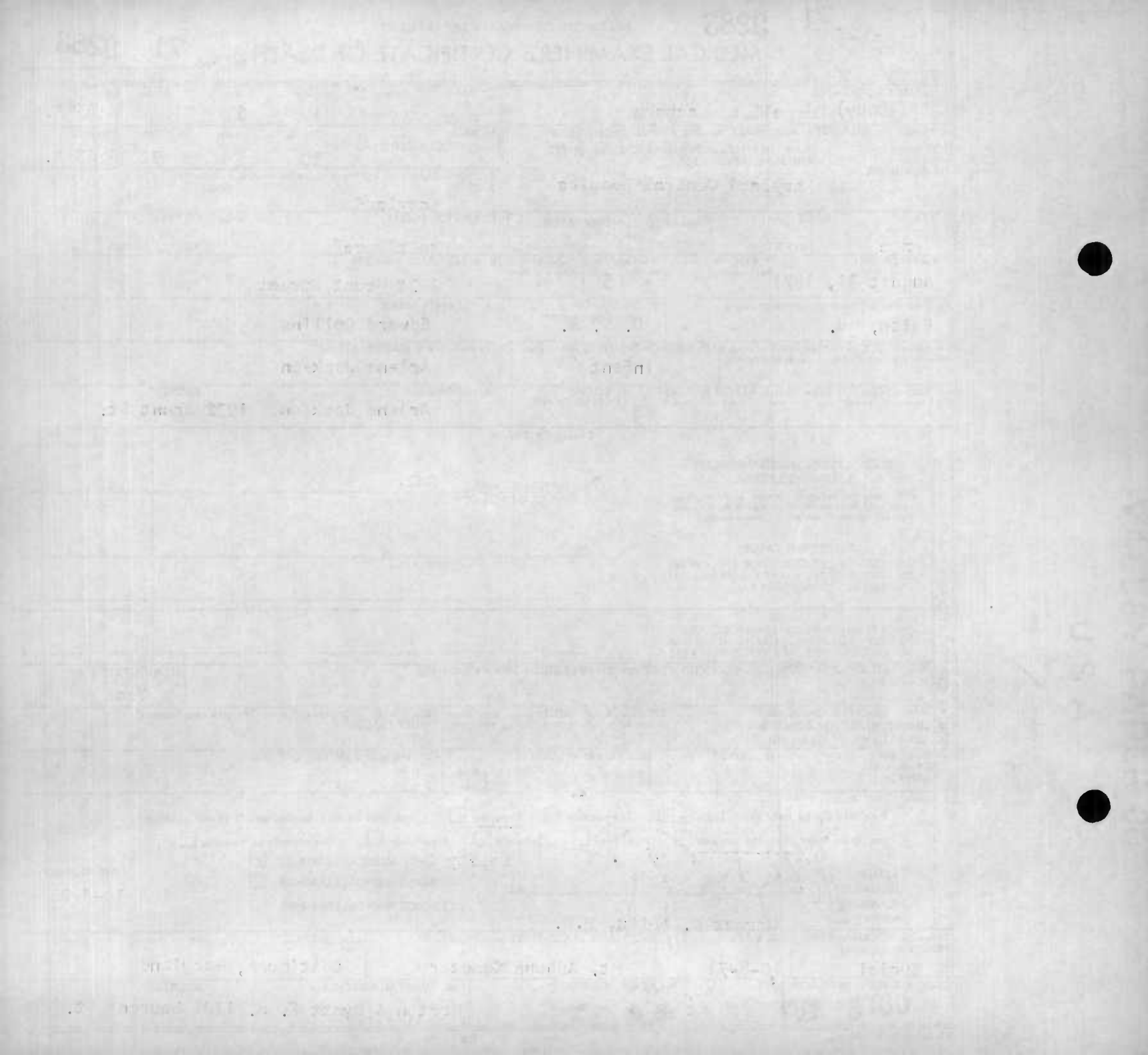
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

11-620 71 9282		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 9282 REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>LOUIS MORRIS</u>		2. DATE AND HOUR OF DEATH <u>10-1-71</u> <u>5:45</u> PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1402</u>		5. CITY OR TOWN <u>BALTO, MD</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hosp</u>		E. STREET AND NUMBER <u>1528-Argyle Ave</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-06</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-01-7908A</u>		17. INFORMANT ADDRESS <u>Mrs. Rose Butler 1615 N. Payson Street</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>C U A (Pneumonia)</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9/17</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u>			
(C) <u>Uremia</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>10-5-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 17</u> 19 <u>71</u> to <u>Oct 1</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Oct 1</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Young</u>		23B. DATE SIGNED <u>10/1/71</u>		23C. PHYSICIAN'S NAME (Type) <u>YOUNG Sook Kim M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-5-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 6 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>	
25C. FUNERAL DIRECTOR <u>1727 N. Monroe Street</u>		25D. ADDRESS			



J-250 9283		BALTIMORE CITY HEALTH DEPARTMENT		71 9283	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. 71-14825					
1. NAME OF DECEASED (Type or Print) (Baby) Cornell E. Jackson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year 10 5 71		Hour 6:45 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital		3. DATE PRONOUNCED DEAD Month Day Year 10 5 71		Hour 6:45 A. M.	
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH August 31, 197		10. AGE (In years lost birthday) 1 5 1		11. BIRTHPLACE (State or foreign country) Balto, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward Collins		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	
15. MOTHER'S MAIDEN NAME Arlene Jackson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Arlene Jackson		ADDRESS 1932 Brunt St.			
19. 795X i DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE SDII DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 10-5-71					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-8-71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. OCT 6 1971		25B. NAME OF REGISTRAR Robert E. Fisher, Jr.	
25C. FUNERAL DIRECTOR Morton & Dyett F. H.		ADDRESS 1701 Laurens St.			



BIRTH NO.		REG. NO.	
R-15271 9284		71 9284	
BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
James Robinson		Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 10 4 71 12:30 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD	
Full Name of Hospital or Institution 39 Provident Hospital		Month Day Year Hour 10 4 71 12:30 P.M.	
6. SEX		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Male		A. STATE B. COUNTY	
7. RACE		Maryland 1602	
Negro		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		E. STREET AND NUMBER	
9-17-30 41		1136 N. Woodyear Street	
10. AGE (in years lost birthday)		11. BIRTHPLACE (State or foreign country)	
41		Chester S. C.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
U.S.A.		Otis Major Robinson	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
Produce		Clara Robinson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
		250-40-3119	
18. INFORMANT		ADDRESS	
Mrs. Mattie Robinson		1136 N. Woodyear	
19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		21. AUTOPSY? (Yes or No)	
2		Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED	
(APPROX.)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
23.		22F. HOW DID INJURY OCCUR?	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
Werner U. Spitz, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		10-9-71	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
A.M.E. Zion Church Ceme.		Calmba, S. C.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
OCT 6 1971		Morton & Dyett F. H.	
25C. FUNERAL DIRECTOR		ADDRESS	
1701 Laurens St.			

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T-460 71

9285

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 9285

1. NAME OF DECEASED (Type or Print) <b>Clarence Taylor</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>10 4 71 4:00 P. M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 Lutheran Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 4 71 4:00 P. M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1604</b>		6. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>6-15-63</b>		10. AGE (In years lost birthday) <b>8</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Taylor, Jr</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Mary M. Jones</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mr. &amp; Mrs. George Taylor, Jr.</b>		ADDRESS <b>815 Brice St.</b>	
19. <b>E814.7</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Multiple injuries</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>in front of 819 Brice Street</b>		22F. HOW DID INJURY OCCUR? <b>Pedestrian-auto accident</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>10 4 71 P. m.</b>		22E. INJURY OCCURRED <b>(5)</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10-5-71</b>			
24A. BURIAL CREMATION, REMOVAL, (Specify) <b>Burial</b>		24B. DATE <b>10-9-71</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1971</b>		25B. NAME OF REGISTRAR <b>N 869.0</b>	
25C. FUNERAL DIRECTOR <b>Morton E. Dyett F. H.</b>		ADDRESS <b>1701 Laurens St.</b>	



THE MEDICAL EXAMINATION REPORT OF THE  
[Illegible text follows, appearing as faint, mirrored bleed-through from the reverse side of the page. The text is largely unreadable due to the quality of the scan and the nature of the bleed-through.]





BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 71-10764 REG. NO. 71 9286

1. NAME OF DECEASED (Type or Print) <b>TYRONE TAYLOR, JR.</b> (Baby)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1206 Argyle Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 4 1971 9:10 a</b> M.	
6. SEX <b>male</b>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1703</b>	
7. RACE <b>negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>6-25-71</b>	10. AGE (In years last birthday) <b>4</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER <b>1206 Argyle Ave.</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto, Md.</b>	12. CITIZEN OF <b>U. S. A.</b>	13. FATHER'S NAME <b>Tyrone Taylor, Sr.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	14B. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>	15. MOTHER'S MAIDEN NAME <b>Erneser Daymon</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	17. SOCIAL SECURITY NO.	18. INFORMANT <b>Mrs. Rosanna Daymon</b> ADDRESS <b>1206 Argyle Avenue</b>	

MEDICAL CERTIFICATION

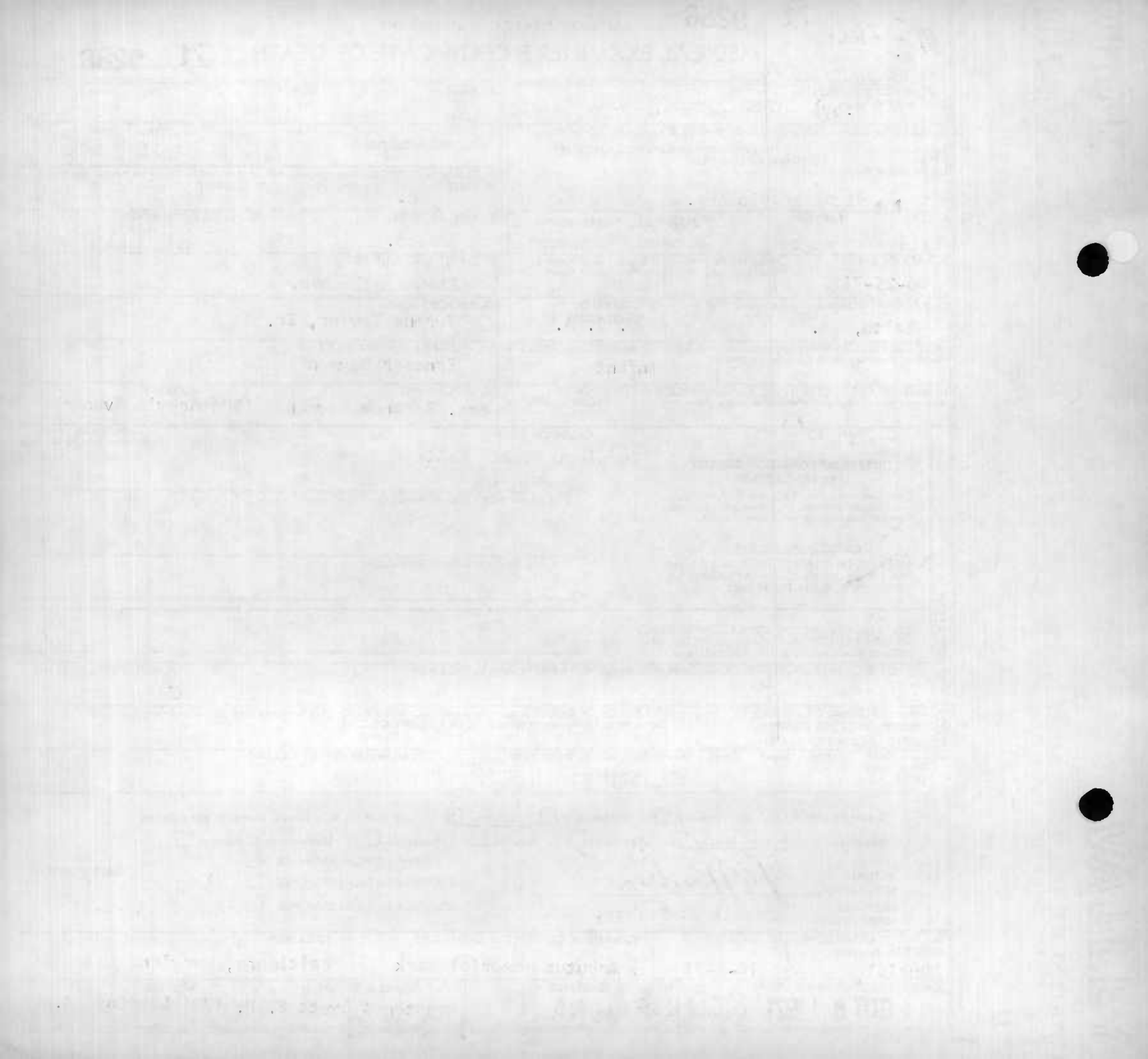
19. **381.9** CAUSE OF DEATH **Burulent otitis media**  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  
(B) DUE TO, OR AS A CONSEQUENCE OF:  
(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  
20A. DATE OF OPERATION **1** 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED \_\_\_\_\_ 21. AUTOPSY? (Yes or No) **yes**

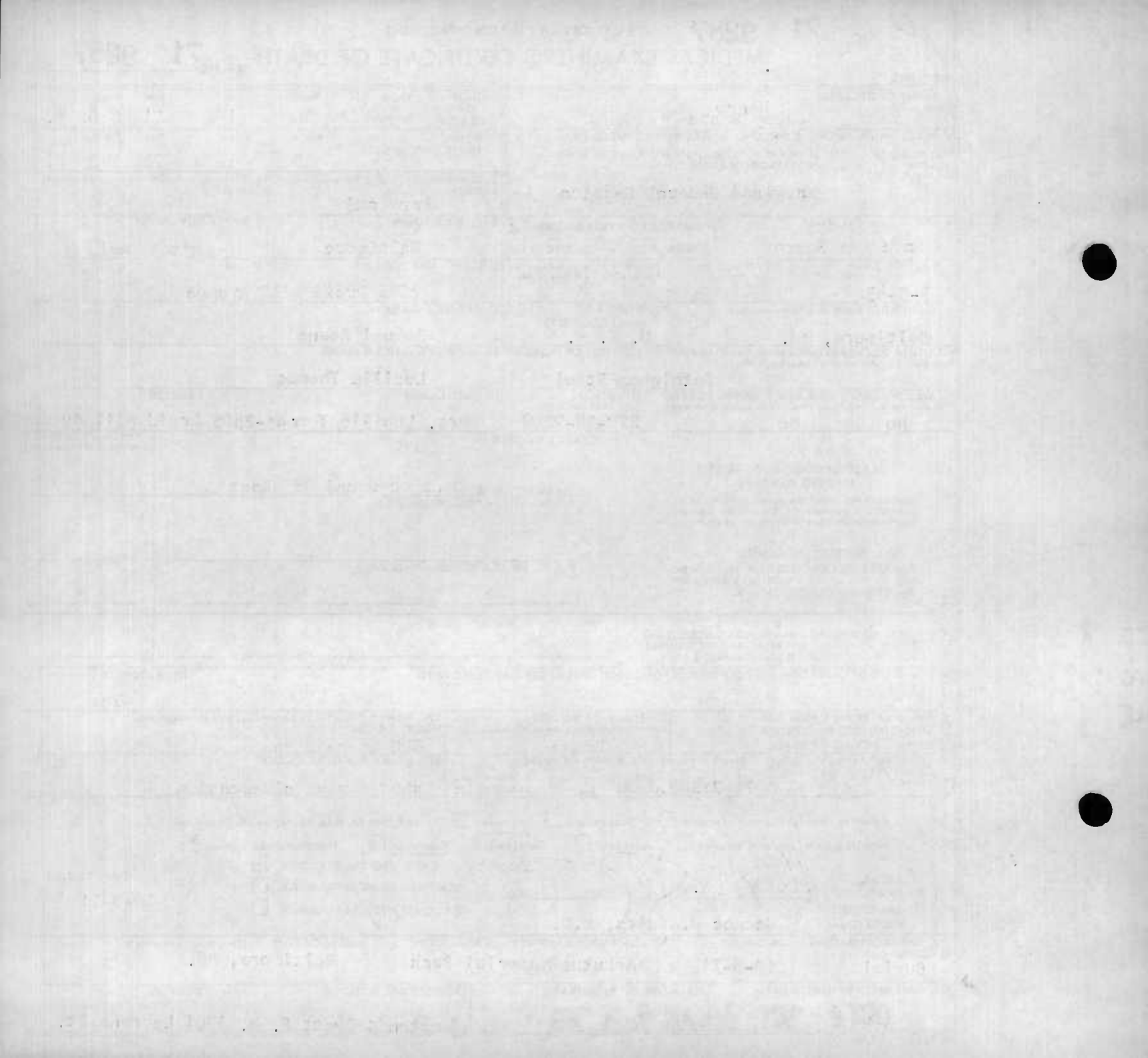
22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐  
ACTUAL SIGNATURE **R. S. Fisher** M.D. CHIEF MEDICAL EXAMINER ☒ DATE SIGNED **10-4-71**  
EXAMINER'S NAME (Type) **Russell S. Fisher, M.D.** ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-8-71</b>	24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 8 1971</b>	25B. NAME OF REGISTRAR <b>Russell S. Fisher, M.D.</b>	25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett F. H.</b>	ADDRESS <b>1701 Laurens St.</b>



1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH		10. AGE (In years lost birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	
Henry Leroy Roane		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 10 Day 4 Year 71		Month 10 Day 4 Year 71		Maryland		Male		Negro				3-5-43		28		Baltimore, Md.		U. S. A.		Samuel Roane		Bethlehem Steel				Lucille Thomas		No		220-38-9208		Mrs. Lucille Thomas-2505 Druid Hill Avenue			
48 Maryland General Hospital		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2505 Druid Hill Avenue																																	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		Gunshot wound of chest		DUE TO, OR AS A CONSEQUENCE OF:																																	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:																																					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)																																					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		Yes																																	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		400 Moore Street		1701																															
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR?		shot during altercation																																	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		10-5-71																													
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Werner U. Spitz, M.D.																																					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		Burial		10-9-71		Arbutus Memorial Park		Baltimore, Md.																									
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS		OCT 6 1971		Morton & Dyett F. H.		1701 Laurens St.																											



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 9288</u>	
<b>BIRTH NO.</b> <u>8-52371</u> <u>9288</u>				<b>1. NAME OF DECEASED</b> (Type or Print) <b>FLOSSIE KNIGHT</b>		<b>2. DATE AND HOUR OF DEATH</b> October 4, 1971 <span style="float: right;">M.</span>	
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <u>34 BON SECOURS HOSPITAL</u>				<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) <b>A. STATE</b> <u>MARYLAND</u> <b>B. COUNTY</b> <u>2002</u>		<b>C. CITY OR TOWN</b> <u>BALTIMORE</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>5. SEX</b> <u>Female</u> <b>6. RACE</b> <u>Negro</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>				<b>8. DATE OF BIRTH</b> <u>March 15, 1897</u> <b>9. AGE</b> (In years last birthday) <u>74</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Norfolk, Virginia</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Unknown</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Lydia Woodhouse</u>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u> <b>16. SOCIAL SECURITY NO.</b> <u>21 9-14-2592</u>	
<b>17. INFORMANT</b> <u>M's. Annie Knight</u> <b>ADDRESS</b> <u>2583 W. Fayette Street</u>				<b>18. CAUSE OF DEATH</b> <u>4123 I</u>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerosis heart disease, Diabetes, Hypertension</u>				<b>(A) IMMEDIATE CAUSE</b> <u>Arteriosclerosis heart disease, Diabetes, Hypertension</u>		<b>DUE TO, OR AS A CONSEQUENCE OF:</b>	
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b>		<b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>	
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>	
<b>19A. DATE OF OPERATION</b>				<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY? (Yes or No)</b>	
<b>20A. AUTOPSY? (Yes or No)</b>				<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>			
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>				<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)				<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) lost saw the deceased alive on <u>October 9,</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <u>[Signature]</u> <b>DEGREE</b> <u>MD</u>				<b>Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input type="checkbox"/>		<b>23B. DATE SIGNED</b> <u>10-5-71</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>F. C. Caguin, M.D.P.A.</u>				<b>23D. ADDRESS</b> <u>230 East 23 Street Balto. MD 21218</u>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>10-8-71</u>		<b>24C. NAME of CEMETERY or CREMATORY</b> <u>Mount Auburn Cemetery</u>		<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Maryland</u>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>OCT 6 1971</u>		<b>25B. NAME OF REGISTRAR</b> <u>[Signature]</u>		<b>25C. FUNERAL DIRECTOR</b> <u>MORTON &amp; DYETT F.H.</u> <b>ADDRESS</b> <u>1701 Laurens Street</u>			

THE UNIVERSITY OF CHICAGO  
LIBRARY  
540 EAST 57TH STREET  
CHICAGO, ILL. 60637

UNIVERSITY OF CHICAGO  
LIBRARY  
540 EAST 57TH STREET  
CHICAGO, ILL. 60637

1 **E-363** 71 9289 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 71 9289  
 REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Carlester Edwards (Edwards)</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>9 30 71 8:30 a.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 30 71 8:30 a.m.</b>	
6. SEX <b>female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>Aug. 11 1936</b>		10. AGE (In years last birthday) <b>35</b>	
11. BIRTHPLACE (State or foreign country) <b>West Va.</b>		12. CITIZEN OF <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		15. MOTHER'S MAIDEN NAME <b>Ruth Lonney</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>None</b>	
18. INFORMANT <b>Blease Edwards</b>		ADDRESS	
19. <b>571.8</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Fatty metamorphosis of liver</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22G. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/5/71</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Culpper National</b>		24D. LOCATION (City, town, or county) (State) <b>Culpper, Va.</b>	
25A. DATE REC'D. BY HEALTH DEPT. <b>OCT 6 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley</b>	
25C. FUNERAL DIRECTOR <b>Kenneth Law</b>		ADDRESS <b>4611 Park Heights Ave.</b>	



(S. 1000) (S. 1000)

1000

U.S.U

1000

17/11



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>71 9290</b>
BIRTH NO. <b>V-24271 9290</b>				
1. NAME OF DECEASED (Type or Print) <b>Finetta Vessells (Vessells)</b>		2. DATE AND HOUR OF DEATH <b>October 1, 1971 6 A. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>39 Provident Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1538</b>		
5. SEX <b>Female</b>		6. RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Oct. 7, 1884</b>		9. AGE (In years last birthday) <b>86</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>8220</b>		11. BIRTHPLACE (State or foreign country) <b>Richmond, Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Allen Harris</b>		
14. MOTHER'S MAIDEN NAME <b>William Thomas</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mabel Hawkins, 3301 Springdale Ave.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ASHD &amp; Permanent Cardiac</b> <b>Asmaller &amp; Renal Failure</b> <b>Diabetes Mellitus</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b> <b>? years</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>7/14</b> 19 <b>71</b> to <b>10/1</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>9/30</b> 19 <b>71</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Elyah Saunders</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>E. J. SAUNDERS</b>
23D. ADDRESS <b>2300 Garrison Blvd.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>10/5/71</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 8 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Kenneth Lay, 4611 Park Heights Ave.</b>

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1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
VIOLA MATTHEWS (Vi. Lee)		Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 30, 1971		Month Day Year September 30, 1971 7:35 A.M.		Johns Hopkins Hospital (DOA)		A. STATE Maryland B. COUNTY 2654	
6. SEX	7. RACE	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
Female	Negro			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
2/13/1932		39		Texas		U.S.A.		Hubert Woods	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME					
Radio Announcer				Viola Bailey					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS			
No				Wellington, Matthews		5127 Darien Road			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)					
2				Yes					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
23.									
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED					
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>							
Charles S. Springate, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		September 30, 1971					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		10/4/71		Woodlawn Cemetery		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
OCT 6 1971		Robert E. Taylor, M.D.		Kenneth Lay		4611 Park Heights Ave.			

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BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 9292  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jerome Sedgewich		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 25 Year 71 Hour 4:10 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month 9 Day 25 Year 71 Hour 4:10 P.M.	
6. SEX female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Nov. 27, 1938		10. AGE (In years lost birthday) 33	
11. BIRTHPLACE (State or foreign country) Beckley, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Gladys Synder	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
Richie & Johnson Funeral, Beckley, W. Va.			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes - (head)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 4302 Adell Terr - Apt. 103		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) 9 25 71 3:30	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> (head)		22F. HOW DID INJURY OCCUR? Subject shot by boyfriend during altercation.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		DATE SIGNED 9/26/71	
24A. BURIAL CREMATION, REMOVAL Burial		24B. DATE 10/3/71	
24C. NAME OF CEMETERY OR CREMATORY Greenwood, Mem.		24D. LOCATION (City, town, or county) (State) Beckley, W. Va.	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR		ADDRESS	
Richie & Johnson F.H.		Beckley W. Va.	



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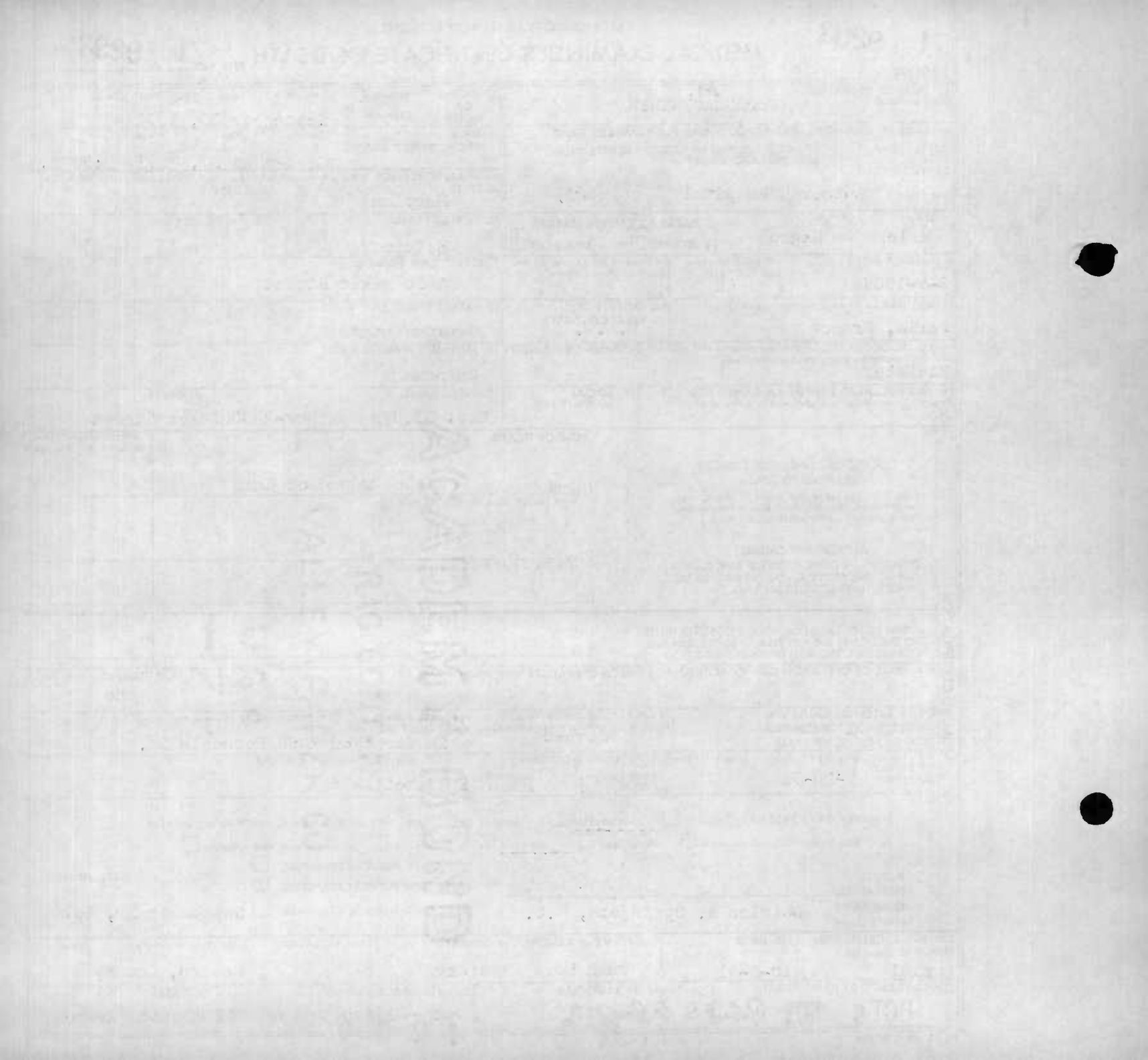
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 9293  
REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>GEORGE GUNTHER</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <b>September 30, 1971</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 30, 1971 9:35 A.M.</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1506</b>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>3-9-1909</b>		10. AGE (In years last birthday) <b>62</b>	11. BIRTHPLACE (State or foreign country) <b>Paris, France</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME <b>George Gunther</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME <b>Unknown</b>	
18. INFORMANT <b>Mrs. Gladys Gunther-2830 Baker Street</b>		ADDRESS			
19. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>E955 I</b>					
(A) IMMEDIATE CAUSE <b>Gunshot wound of head</b> DUE TO, OR AS A CONSEQUENCE OF:					
(B) _____ DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>in front of 1008 Rosedale St. 1607</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>9-30-71</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot self</b>	
23.					
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Springate</b>		M.D. <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> <b>September 30, 1971</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-5-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Bush Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Howard, County</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Fagley, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Mary-Elizabeth Law</b>		ADDRESS <b>802 Madison Avenue</b>			



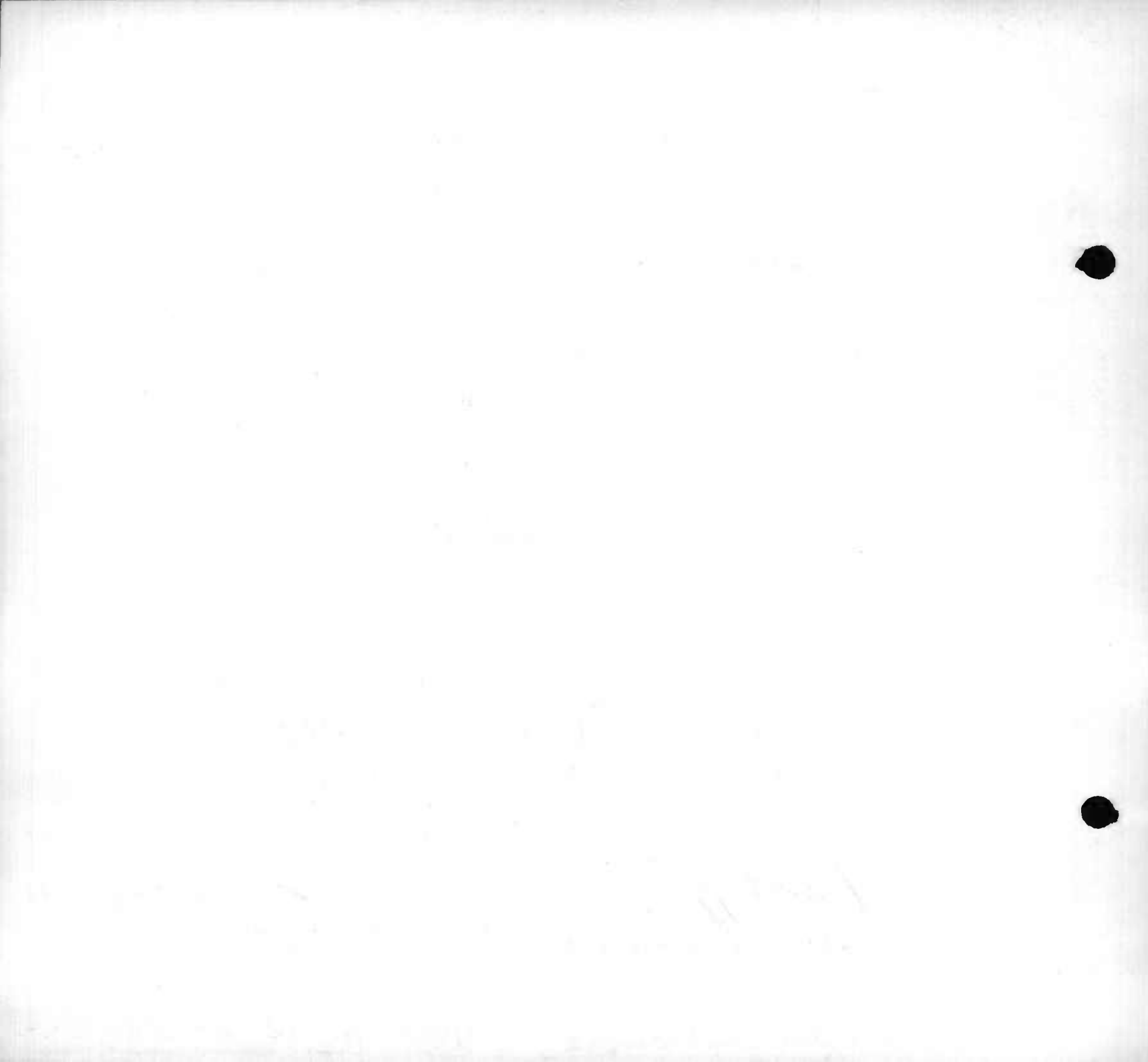




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 9294		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 9294	
1. NAME OF DECEASED (Type or Print) <u>Louise F. Belton</u>			2. DATE AND HOUR OF DEATH <u>10-3-71</u> <u>6 15/P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2002</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 Bon Secours Hospital</u> <u>2025 W. Fayette St.</u>			C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>100 Wheeler Ave.</u>					
5. SEX <u>Female</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-16-10</u>	9. AGE (in years last birthday) <u>61</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maid</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Bon Secours Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Willie FRAZIER</u>			14. MOTHER'S MAIDEN NAME <u>Fletcher, Ella</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-8283</u>		17. INFORMANT <u>Charles Frazier</u> ADDRESS <u>114 M ST. ALBANY, N.Y. 11412</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CA, metastatic to lungs and abdomen from CA of uterus.</u>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>					
19A. DATE OF OPERATION <u>10-3-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>N/A</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>N/A</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>N/A</u>	
21D. TIME OF INJURY (APPROX.) <u>N/A</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>N/A</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>8-25</u> 19 <u>71</u> to <u>10-3</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10-3 (6:5 PM) 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>			23B. DATE SIGNED <u>Oct-3, 1971</u>		
23C. PHYSICIAN'S NAME (Type) <u>GERARDO M Lopez M.D.</u>			23D. ADDRESS <u>Bon Secours Hospital</u> <u>2025 W. Fayette, BALTO. MD 21223</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-7-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	
24D. LOCATION <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 6 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Frazier</u>		25C. FUNERAL DIRECTOR <u>Charles D. Rice</u> ADDRESS <u>661 W. Barre St.</u>	



**BALTIMORE CITY HEALTH DEPARTMENT**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** **71 9295**  
 REG. NO. **71 9295**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Charles E. Kea</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>3</b> Year <b>1971</b> Hour <b>8:40 p</b> M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2843</b>			
6. SEX <b>male</b>	7. RACE <b>negro</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>1-12-1926</b>		10. AGE (In years last birthday) <b>45</b>		E. STREET AND NUMBER <b>4210 Fairview Ave.</b>			
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Willie Moore</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Sparrows Point</b>		15. MOTHER'S MAIDEN NAME <b>Alice Ewell</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes World War II</b>		17. SOCIAL SECURITY NO. <b>212-26-2781</b>		18. INFORMANT <b>Mrs. Bertha Lee Kea</b>		ADDRESS <b>4210 Fairview Ave.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Multiple gunshot wounds of abdomen</b>		CAUSE OF DEATH <b>Multiple gunshot wounds of abdomen</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
		(B) DUE TO, OR AS A CONSEQUENCE OF:					
		(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION <b>10-2-71</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Longwood &amp; Westwood St.</b>		1506	
22D. TIME OF INJURY (APPROX.) <b>10-2-71 8:20 p</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot by assailant.</b>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>10-4-71</b>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-8-1971</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME</b>		ADDRESS <b>3035 W. NORTH AV</b>	

TO : DIRECTOR, FBI (100-388610)  
FROM : SAC, NEW YORK (100-100000) (P)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph memorandum or letter.]

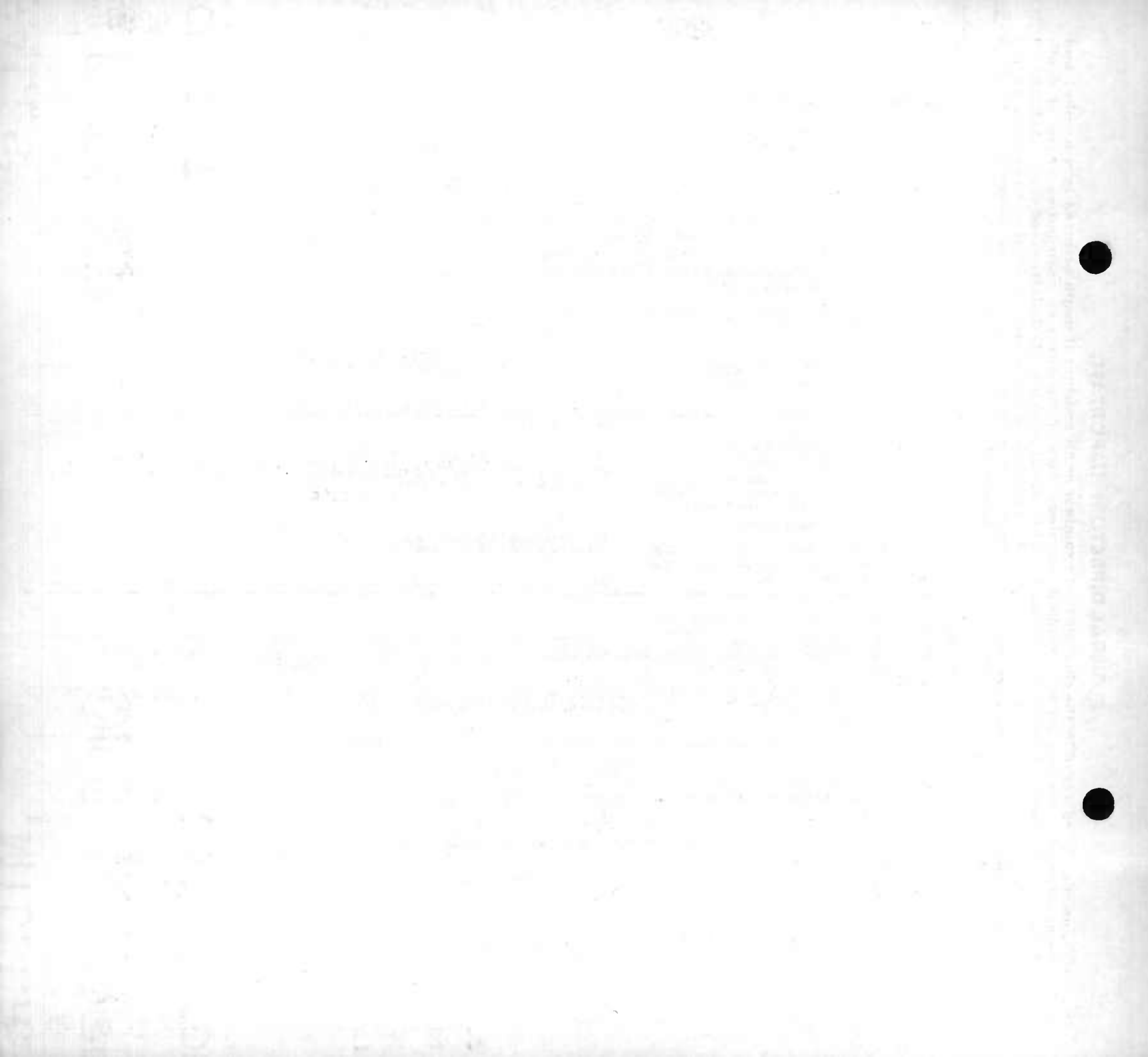
Very truly yours,  
[Illegible Signature]  
Special Agent in Charge

100-388610-100000  
JAN 12 1964  
FBI - NEW YORK

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">C-236 71 9296</span>				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">71 9296</span>	
1. NAME OF DECEASED (Type or Print) <b>Joseph M. Caster</b>				2. DATE AND HOUR OF DEATH <b>October 4, 1971</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1001</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Bon Secours Hospital</b> <b>34</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1010 N. Payson Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-10-1901</b>	9. AGE (In years last birthday) <b>70</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>moving &amp; hauling</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Spencer Caster</b>				14. MOTHER'S MAIDEN NAME <b>Jenette Campbell</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>217-01-0998</b>		17. INFORMANT <b>Mrs. Helen E. Caster</b>		
			ADDRESS <b>1010 N. Payson St.</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Abdominal Carcinoma</b>				APPROXIMATE INTERVAL BETWEEN ONSET OF DEATH <b>10/28/70</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Carcinoma Sigmoid Colon</b>				DUE TO, OR AS A CONSEQUENCE OF: <b>2/12/59</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>8/7/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bowel Obstruction</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>2/9/69</b> 19 <b>71</b> to <b>9/14</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>9/14</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>William R. Lumpkin</b>						23B. DATE SIGNED <b>10/5/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>William R. Lumpkin</b>						23D. ADDRESS <b>M. D. 1114 St. Paul Street</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-8-1971</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Soley, Jr.</b>		25C. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME 3035 W. NORTH AVE</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9297

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William A. Lansey Sr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 1 Year 71 Hour 6:20 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1632 Druid Hill Avenue		3. DATE PRONOUNCED DEAD Month 10 Day 1 Year 71 Hour 6:20 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1402			
6. SEX male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. DATE OF BIRTH 12-24-1921
10. AGE (In years lost birthday) 49		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Teackle W. Lansey		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Security Guard	
15. MOTHER'S MAIDEN NAME Josephine Gaines		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes World War II	
17. SOCIAL SECURITY NO. 217-16-6232		18. INFORMANT Mr. William A. Lansey Jr.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/2/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-7-1971	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AV	

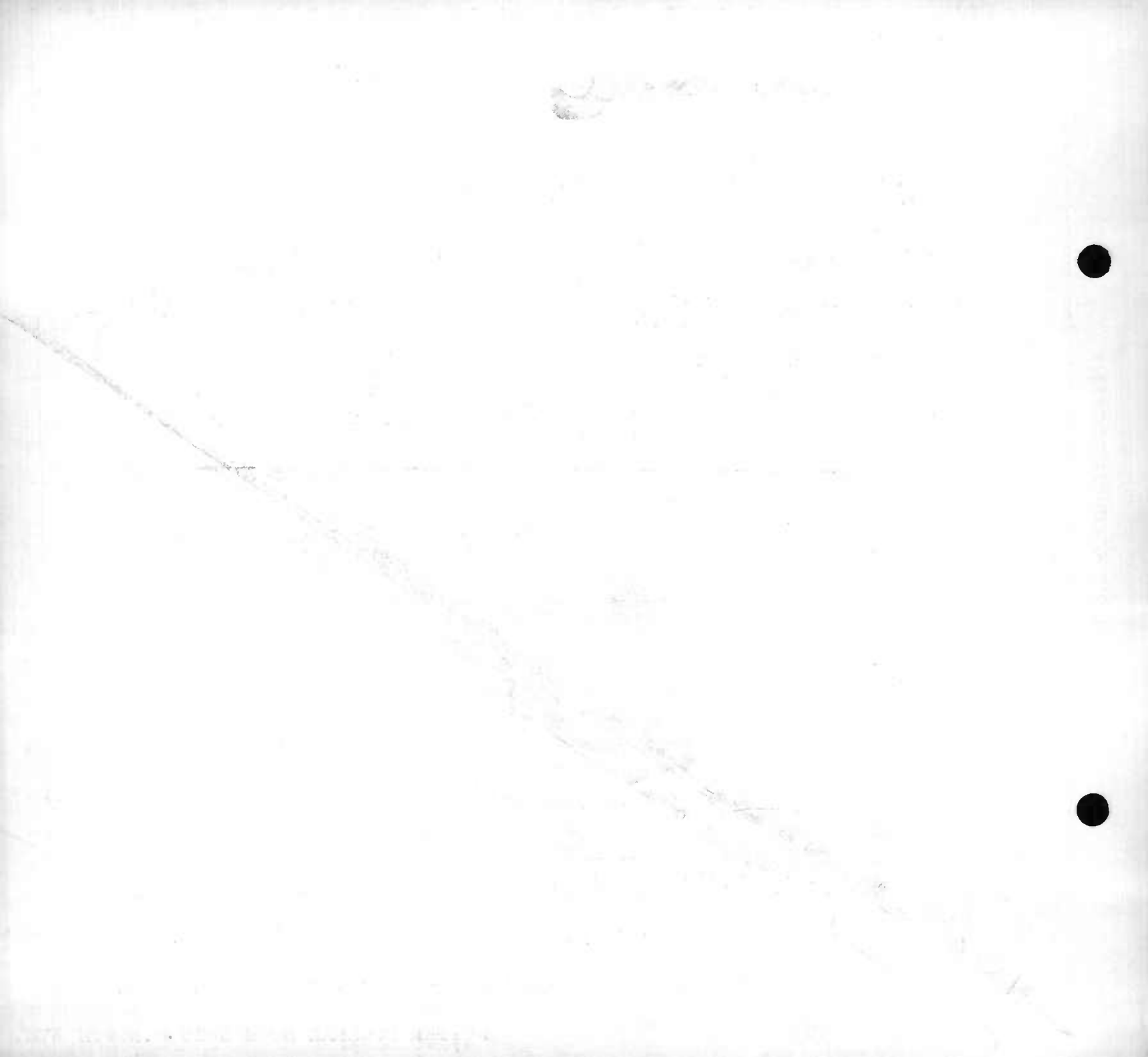




# FUNERAL DIRECTOR: IMPORTANT

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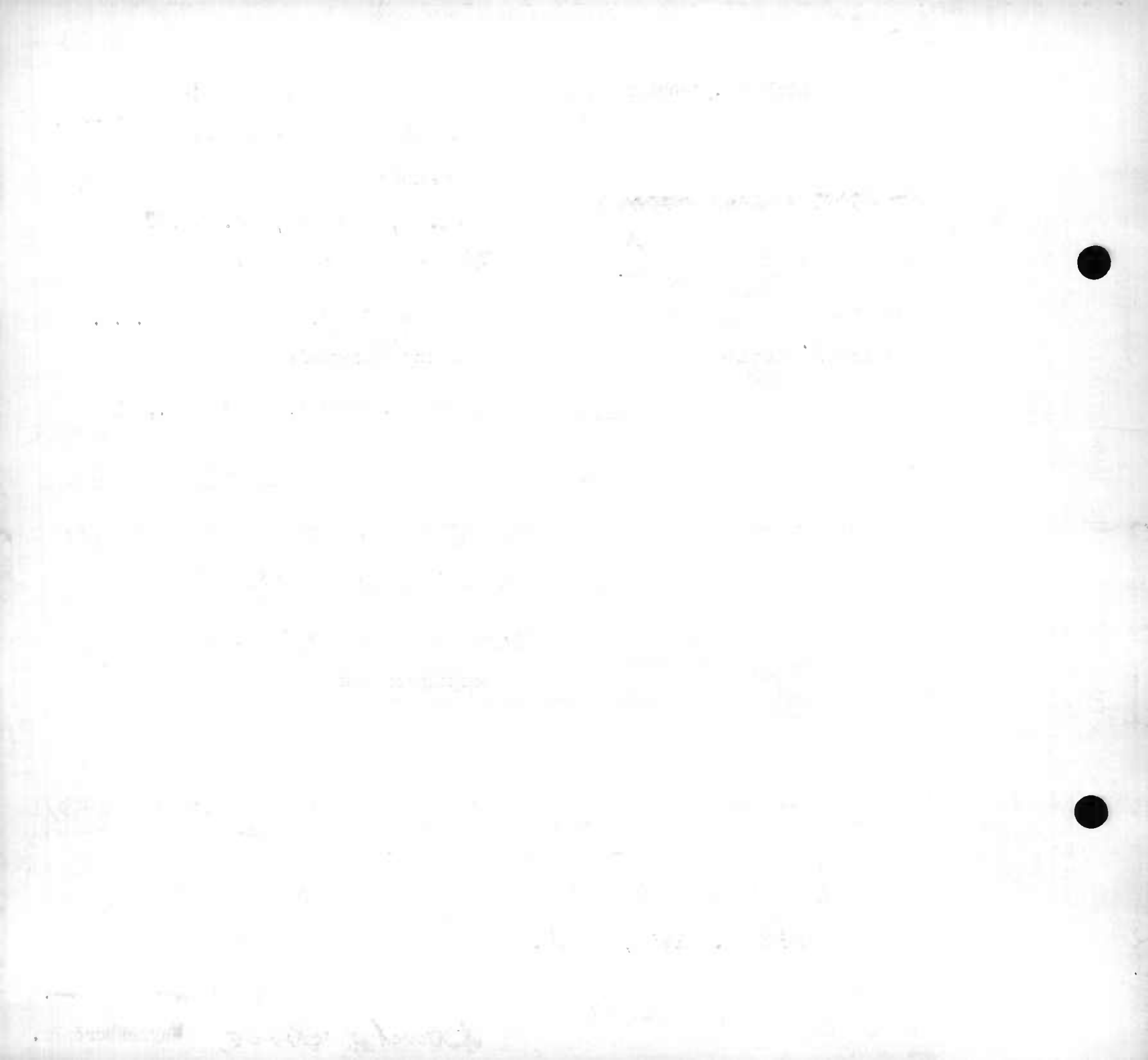
<div style="display: flex; justify-content: space-between;"> <span>D-120 71 9298</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> <span>REG. NO. 71 9298</span> </div>					
BIRTH NO. _____		1. NAME OF DECEASED: (Type or Print) <b>William B. Davis Sr.</b>		2. DATE AND HOUR OF DEATH <b>10-4-71 6:20 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>North Charles Gen. Hosp</b>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1607</b>	
				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3017 Grayson St.</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-7-09</b>	9. AGE (in years last birthday) <b>62</b>	11. Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Storage clerk</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Mano Swartz Furrier</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>John H. Davis</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Lee</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>218-01-0829</b>			17. INFORMANT <b>Mrs. Dorothy E. Davis</b> ADDRESS <b>3017 Grayson St</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiorespiratory Arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cancer of Esophagus</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs.</b>					
19A. DATE OF OPERATION <b>9/15/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer of Esophagus</b>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White Al <input type="checkbox"/> Not White Al Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 2/71</b> 19 <b>71</b> to <b>Oct. 4</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>Oct. 4</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Narciso E. IGNACIO, M.D.</b>				23B. DATE SIGNED <b>10-4-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Narciso E. IGNACIO, M.D.</b>				23D. ADDRESS <b>North Charles Gen. Hosp., Balto., Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-9-71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1971</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME</b> ADDRESS <b>3035 W. NORTH AVE.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

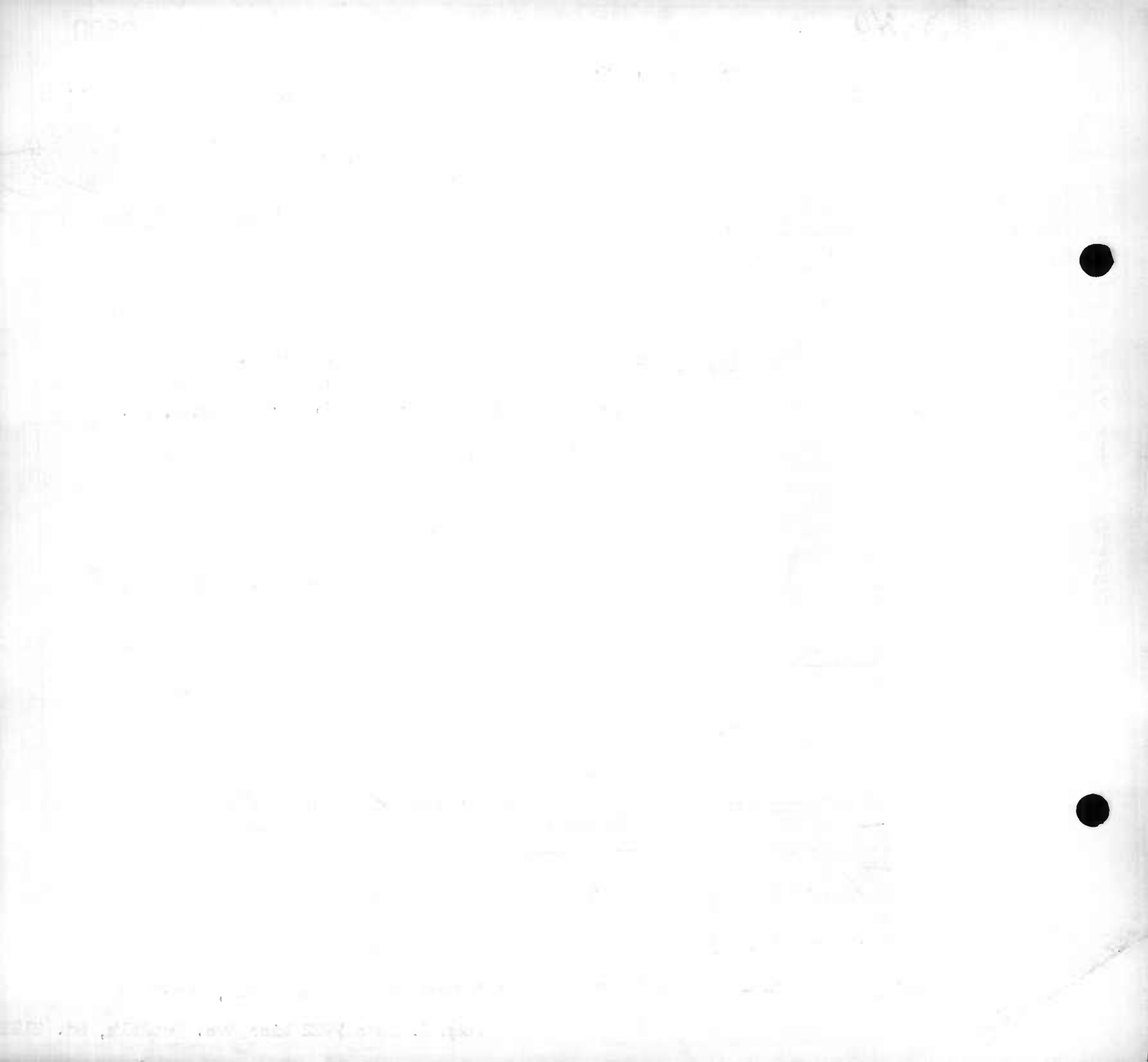
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9299</u>	
BIRTH NO. <u>D-152 71 9299</u>		1. NAME OF DECEASED (Type or Print) <u>Shirley A. Dobbins</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Washington</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Johns Hopkins Hospital</u>		C. CITY OR TOWN <u>Cascade</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>Rt. 1, Cascade, Md. 21719</u>			
5. SEX <u>F</u>	6. RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/5/44</u>	9. AGE (In years last birthday) <u>27</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence Dingle</u>		14. MOTHER'S MAIDEN NAME <u>Betty Alexander</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Francis E. Dobbins, Cascade Md., #1</u>	
18. <u>020X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Ventricular Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hepatic coma</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Acute fulminant Hepatitis ? dx</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>5 d.</u> <u>7 d</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A). <u>Halothane Anesthesia</u>					
19A. DATE OF OPERATION <u>Sept 25</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>xxxxxxx Yes</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 25</u> 19 <u>71</u> to <u>Oct 1</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Oct 1</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Keith L. Klein M.D.</u>		23B. DATE SIGNED <u>10/1/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Keith L. Klein, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/4/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Bethel</u>	
24D. LOCATION (City, town, or county) <u>Frederick County</u>		24E. STATE <u>Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 6 1971</u>	
25B. NAME OF REGISTRAR <u>Robert E. Miller, M.D.</u>		25C. FUNERAL DIRECTOR <u>David H. Grove</u>		25D. ADDRESS <u>Waynesboro Pa.</u>	



FUNERAL DIRECTOR: IMPORTANT

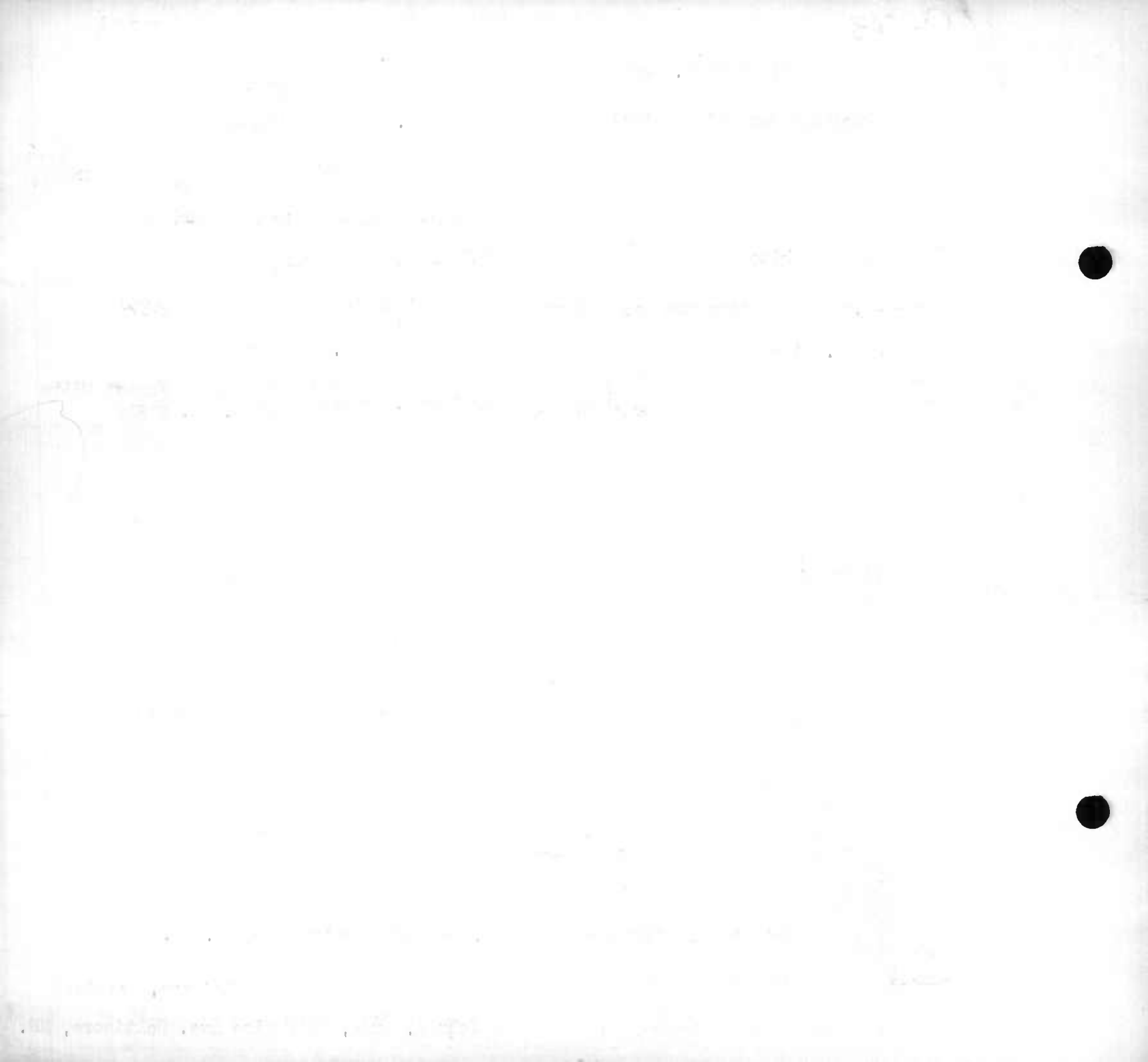
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9300</u>	
<p><u>D-240</u> <u>71 9300</u></p> <p>BIRTH NO. <u>71 9300</u></p> <p>1. NAME OF DECEASED <u>Leroy J. Dushel, Jr.</u> (Type or Print) <u>Leroy Dushel Jr.</u></p>		<p>2. DATE AND HOUR OF DEATH <u>October 2, 1971</u> <u>105 A.M.</u></p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION <u>48</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND General Hospital</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)</p> <p>A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore County</u></p> <p>C. CITY OR TOWN <u>Dundalk</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER <u>1737 Burnham Road</u></p>			
<p>5. SEX <u>Male</u></p>	<p>6. RACE <u>Caucasian</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>12-25-52</u></p>		<p>9. AGE (in years last birthday) <u>18</u></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <u>—</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>Maryland</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>		<p>13. FATHER'S NAME <u>Leroy Dushel Sr.</u></p>			
<p>14. MOTHER'S MAIDEN NAME <u>Frances E. Reick</u></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p>			
<p>16. SOCIAL SECURITY NO. <u>213-62-1790</u></p>		<p>17. INFORMANT <u>Father: Leroy J. Dushel, Sr.</u> ADDRESS <u>1737 Burnham Road Dundalk, Md. 21222</u></p>			
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Pulmonary congestion &amp; edema</u></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p>		<p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Aspiration</u></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u></p>	
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u></p>		<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <u>—</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u></p>		<p>20A. AUTOPSY? (Yes or No) <u>yes</u></p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u></p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>			
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u></p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u></p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>—</u></p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? <u>—</u></p>	
<p>22. I certify that (I) (<del>this hospital</del>) attended the deceased from <u>October 1, 1971</u> to <u>October 2, 1971</u> and that (I) (<del>we</del>) last saw the deceased alive on <u>October 1, 1971</u> and that (in my) (<del>our</del>) opinion death occurred on the date and hour and from the causes stated above. (I) (<del>we</del>) (<del>did not</del>) view the body after death.</p>					
<p>23A. SIGNATURE <u>Richard C. Keown MD</u></p>		<p>23B. DATE SIGNED <u>October 2, 1971</u></p>		<p>23C. PHYSICIAN'S NAME (Type) <u>Richard C. Keown MD</u></p>	
<p>23D. ADDRESS <u>Maryland General Hospital</u></p>		<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>			
<p>24B. DATE <u>10-5-71</u></p>		<p>24C. NAME OF CEMETERY OR CREMATORY <u>Holly Hill Memorial Gardens</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>White Marsh, Maryland</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>OCT 6 1971</u></p>		<p>25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD</u></p>		<p>25C. FUNERAL DIRECTOR ADDRESS <u>John J. Duda 7922 Wise Ave. Dundalk, Md. 21222</u></p>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. <u>71 9301</u>	
C-563 <u>71 9301</u>		BIRTH NO.		1			
1. NAME OF DECEASED <u>Elizabeth L. Conrad</u> (Type or Print) <u>ELIZABETH CONRAD</u>				2. DATE AND HOUR OF DEATH <u>10/2/71 10:05 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Maryland General Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MARYLAND GENERAL HOSPITAL</u> <u>827 LINDEN ST. BALTO. MD 21201</u>				C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>2114 LODGE FOREST Drive</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>07/08/25</u>	9. AGE (In years last birthday) <u>46</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CASHIER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Savemore Food Store</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Earl L. Dixon</u>				
14. MOTHER'S MAIDEN NAME <u>Agnes L. Cortney</u>					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>5B-26-7330</u>					17. INFORMANT <u>Husband:</u> <u>Stanley M. Conrad</u> ADDRESS <u>2114 Lodge Forest Drive Balto. Md. 21219</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u> 20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NO</u> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NO</u> 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>NO</u> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <u>NO</u> 21F. HOW DID INJURY OCCUR? <u>NO</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>2 yr.</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>September 20, 1971</u> to <u>October 2, 1971</u> that (I) (we) last saw the deceased alive on <u>10/2/71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Phillip E. Middleton</u>				23B. DATE SIGNED <u>10/2/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Phillip E. Middleton</u>	
23D. ADDRESS <u>Md. General Hospital Balto. Md.</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>10/4/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 6 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Md.</u>		25C. FUNERAL DIRECTOR <u>John J. Duda</u> ADDRESS <u>7922 Wise Ave. Baltimore, Md.</u>			





1  
J-525-71 9302 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 9302  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PAUL F. JOHNSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 4 1971 4:16 a M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Belair	
9. DATE OF BIRTH Jan. 3, 1944		10. AGE (In years last birthday) 27	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		14B. KIND OF BUSINESS OR INDUSTRY auto	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 220-40-8680	
18. INFORMANT Joyce Johnson, 1900 Conowingo Road, Bel Air, Md.		ADDRESS Md.	

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple body injuries		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(B) DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		

20A. DATE OF OPERATION	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) shopping plaza	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Belair Shopping Plaza - Harford Co.
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 10-4-71 3:10 a m.	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	22F. HOW DID INJURY OCCUR? Subj. in altercation. Assailant ran him over with truck.

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE: Russell S. Fisher M.D.  
EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 10-4-71

24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Oct. 6, 1971	24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial Gardens	24D. LOCATION (City, town, or county) (State) Bel Air Harford Md.
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1971	25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	25C. FUNERAL DIRECTOR Howard K. McComas, III, Abingdon, Md.	ADDRESS

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THE UNIVERSITY OF CHICAGO

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9303</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">E-524</span>		<span style="font-size: 1.5em;">71 9303</span>		<b>CERTIFICATE OF DEATH</b>	
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">ETHEL MINERVA ENGLER</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">OCT. 3, 1971</span> <span style="float: right;">6<sup>30</sup> A.M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">MARYLAND GENERAL HOSPITAL</span> <span style="font-size: 1.5em;">48</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.5em;">2758</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">BALTIMORE</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">5124 GREENWICH AVE.</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">F</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">W</span>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">JUNE 21, 1898</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">73</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired Teacher</span>			<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Emory Elton Engler</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Flora Jane Bailey</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">214-40-2829</span>		<b>17. INFORMANT ADDRESS</b> <span style="font-size: 1.2em;">Silver Cross Home, 5124 Greenwich Ave. 21229</span>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <span style="font-size: 1.5em;">433.9 H 250.9</span> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <div style="text-align: center;">II</div> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>			<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">CEREBRAL THROMBOSIS</span> (B) <span style="font-size: 1.2em;">CEREBRAL ARTERIOSCLEROSIS</span> DUE TO, OR AS A CONSEQUENCE OF: (C) _____  <div style="display: flex; justify-content: space-between;"> <span>① <span style="font-size: 1.2em;">DIABETES MELLITUS</span></span> <span>② <span style="font-size: 1.2em;">URINARY TRACT INFECT.</span></span> </div>		
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">O</span>			<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)			<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)			<b>21E. INJURY OCCURRED</b> White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">AUGUST 30</span> 1971 to <span style="font-size: 1.2em;">OCTOBER 3</span> 1971 that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">OCTOBER 2</span> 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Edward F. Cotter M.D.</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">Oct. 3, 1971</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Edward F. Cotter</span>			<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">216 MEDICAL ARTS BUILDING, BALTO, Md.</span>		
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">10-6-1971</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Druid Ridge Cemetery</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Pikesville, Maryland</span>					
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">OCT 6 1971</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert C. ...</span>		<b>25C. FUNERAL DIRECTOR ADDRESS</b> <span style="font-size: 1.2em;">Howard H. Hubbard, 4107 Wilkens Ave. 21229</span>	

5402 Beechdale Ave

Adm. 6/2/71

CT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

REG. NO. 71 9304

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Elizabeth C. HANNA

2. DATE AND HOUR OF DEATH

10-4-71

1 9<sup>25</sup> A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)4.4  
UNION

Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4422 Powell

Ave.

5. SEX

F

6. RACE

W

7. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

03-25-84

9. AGE (in years  
last birthday)

87

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Von Henie Co.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

JAMES

HANNA

14. MOTHER'S MAIDEN NAME

Clara Schneider

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

216-01-0080

17. INFORMANT

Elizabeth New 4422 Powell Ave. Balto. Md.

ADDRESS

21236

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoarthritis, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cerebral ischemia

(B) ASCVD - CUA.

DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9-18-71 19 to 10-4-71 19  
that (I) (we) last saw the deceased alive on 10-4-71 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Jairo Ramirez MD

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

10-4-71

23C. PHYSICIAN'S  
NAME (Type)

Jairo Ramirez

DEGREE

23D. ADDRESS

UNION Memorial Hospital

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10-7-71

24C. NAME of CEMETERY or CREMATORY

German E.V. Lutheran Cemetery

24D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

OCT 6 1971

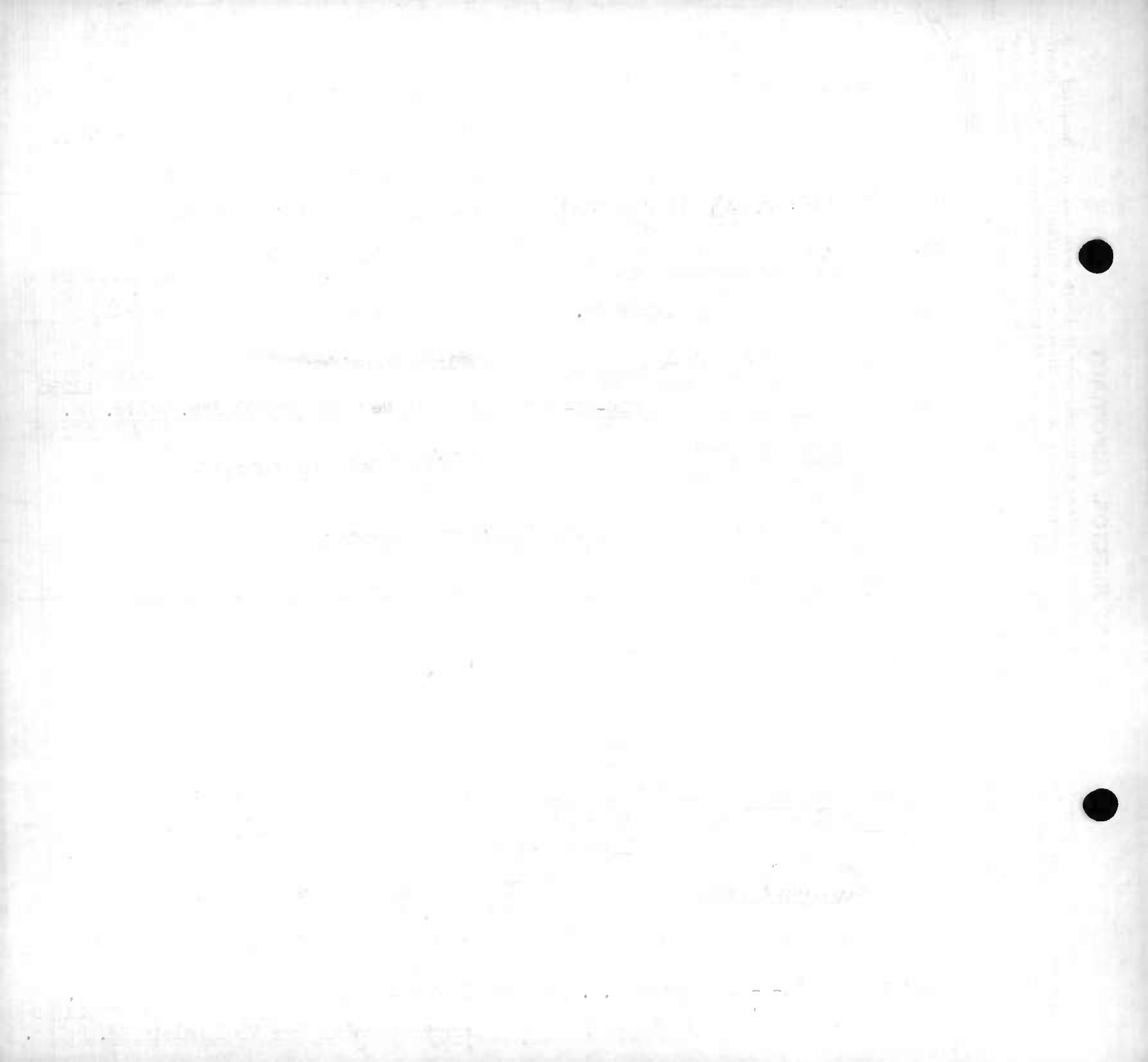
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Lasson Funeral Home 7401 Belair Rd. Balto.

ADDRESS 21236



9305

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9305

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)B.  
Fred Woodson2. DATE  
OF  
DEATHKnown ☒  
Estimated ☐Month  
10Day  
2Year  
71Hour  
1:20 a.  
M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 University Hospital

3. DATE  
PRONOUNCED DEADMonth  
10Day  
2Year  
71Hour  
1:20 a.  
M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md.

Harford

6. SEX

male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Aberdeen

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Aug. 4, 1925

10. AGE (In years last birthday)

46

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

63B Elm St.

11. BIRTHPLACE (State or foreign country)

Bristol, Tenn.

12. CITIZEN OF

WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Fred W. Woodson

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Mail Carrier

14B. KIND OF BUSINESS OR INDUSTRY

G. P. O.

15. MOTHER'S MAIDEN NAME

Corrie Mae Williams

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)

yes 1948-1952

17. SOCIAL SECURITY NO.

223-26-4411

18. INFORMANT

Mrs. Charlene H. Woodson, Aberdeen, Md.

ADDRESS 633 Elm St.

19.

5-8-20

CAUSE OF DEATH

Fracture of cervical spine  
with transection of brain stemAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)  
HIGHWAY22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR? U.S. 40 - 1 mile west of  
Aberdeen, Md.22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

10 2 71 12:05 a.m.

22E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject driver in auto/auto collision.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
10/2/7124A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10-9-71

24C. NAME OF CEMETERY or CREMATORY

Citizens Cemetery

24D. LOCATION (City, town, or county) (State)

Bristol, Va.

25A. DATE REC'D BY HEALTH DEPT.

OCT 6 1971

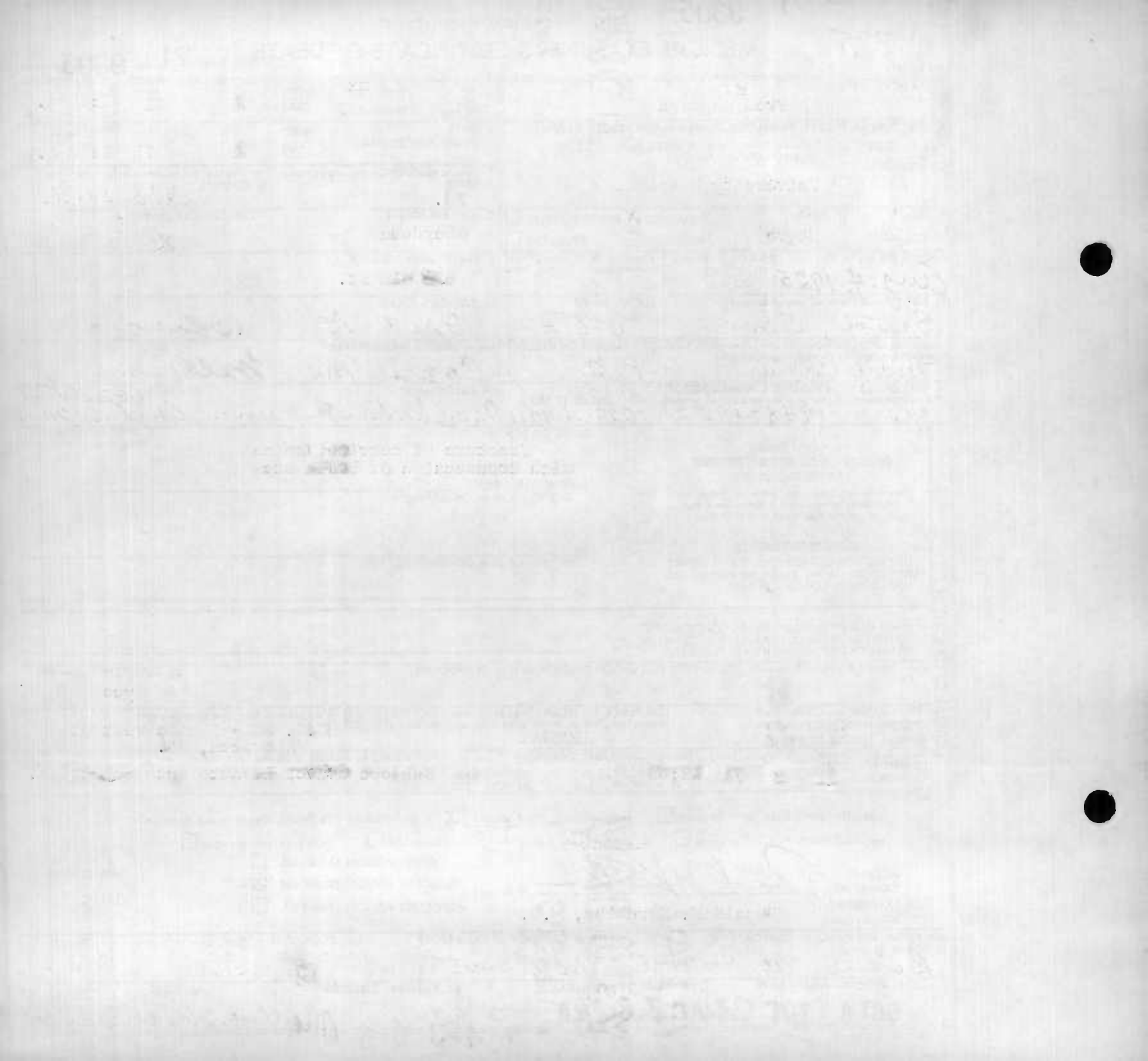
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Otelia J. Bullock, Harford County, Md.

ADDRESS 556 Lewis St.

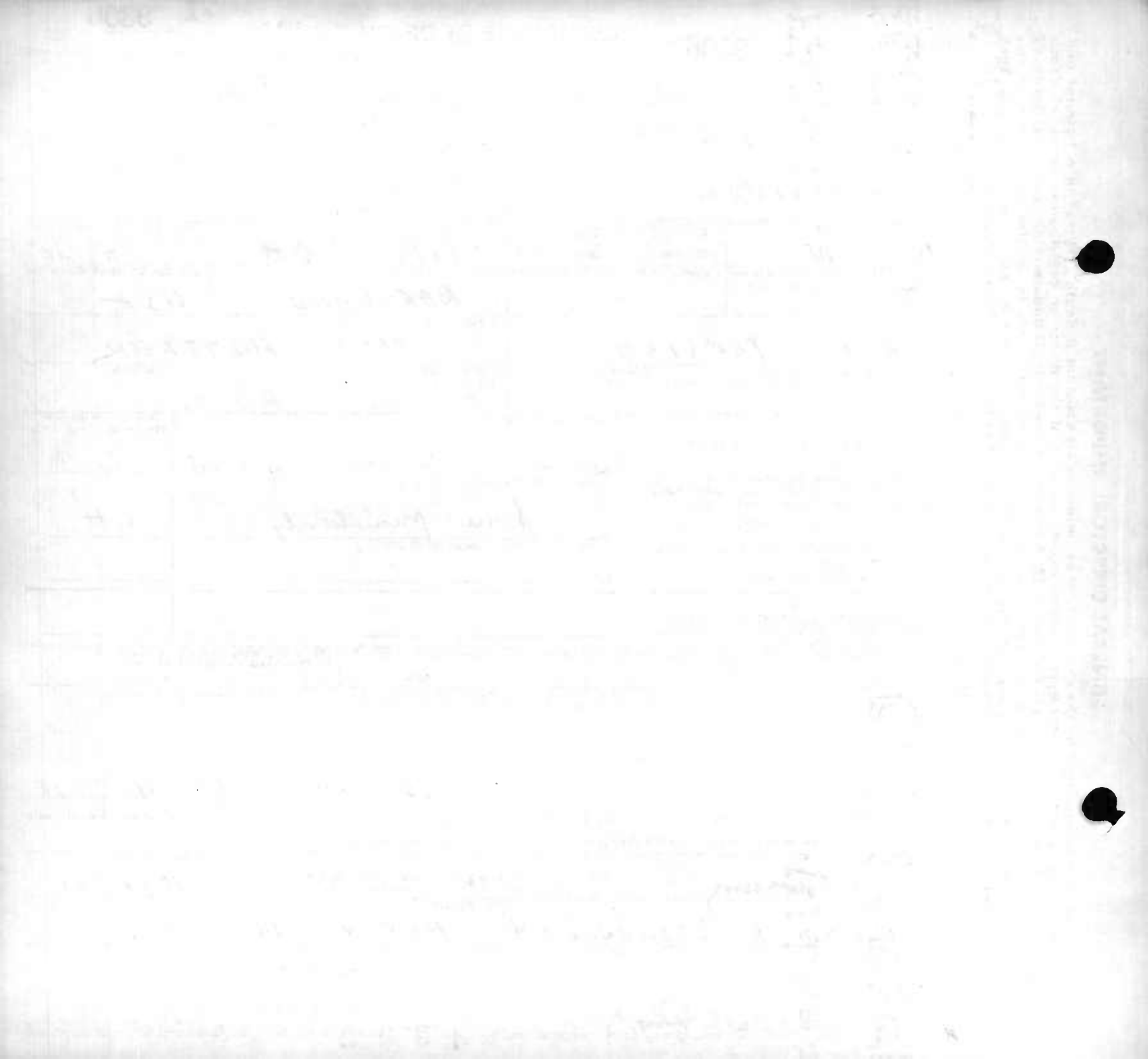




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

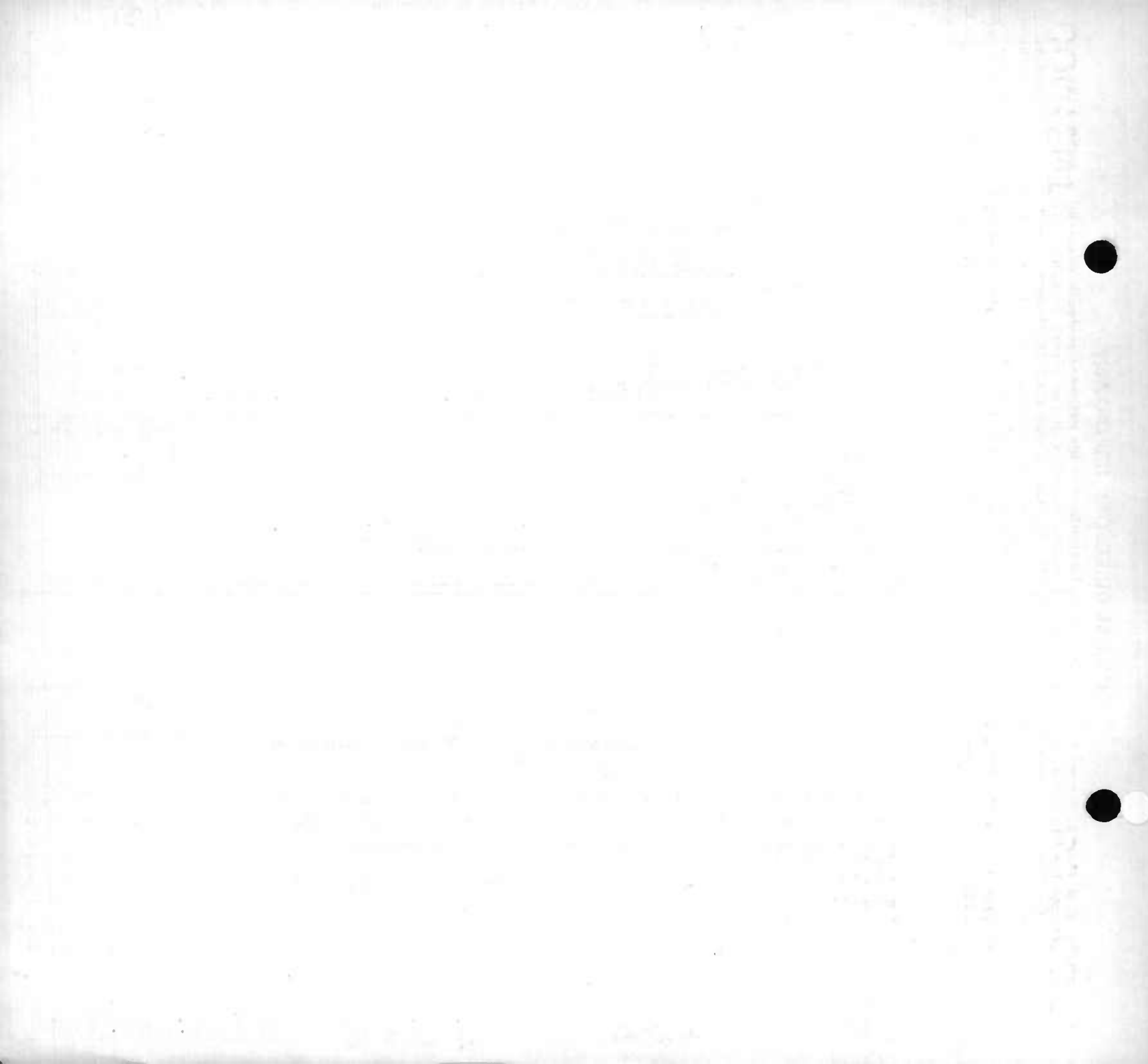
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <span style="font-size: 1.5em;">71</span> <span style="font-size: 1.5em;">9306</span>	
BIRTH NO. <span style="font-size: 1.5em;">P-625</span> <span style="font-size: 1.5em;">71-1678471</span> <span style="font-size: 1.5em;">9306</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.5em;">10/4/71</span> <span style="font-size: 1.5em;">1030 PM</span>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.5em;">BABY BOY PERSING</span>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.5em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">2633</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">MERCY HOSPITAL</span>				C. CITY OR TOWN <span style="font-size: 1.5em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <span style="font-size: 1.5em;">Maryland</span>							
5. SEX <span style="font-size: 1.5em;">M</span>	6. RACE <span style="font-size: 1.5em;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.5em;">10/4/71</span>	9. AGE in years last birthday <span style="font-size: 1.5em;">0</span>	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">MARYLAND</span>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.5em;">USA</span>		
13. FATHER'S NAME <span style="font-size: 1.5em;">JAMES PERSING</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">ANNA BUETTNER</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.5em;">James Persing</span> <span style="font-size: 1.5em;">3401 Ramona Ave., Baltimore, Md.</span>		
18. <span style="font-size: 1.5em;">77819</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Cardio respiratory arrest</span>  (B) <span style="font-size: 1.5em;">Severe prematurity</span> DUE TO, OR AS A CONSEQUENCE OF:  (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <span style="font-size: 1.5em;">15 min</span>  <span style="font-size: 1.5em;">5 H</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <span style="font-size: 1.5em;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.5em;">NO</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">Oct 4/71</span> 1971 to <span style="font-size: 1.5em;">Oct 4</span> 1971 that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">Oct 4</span> 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.5em;">[Signature]</span>				23B. DATE SIGNED <span style="font-size: 1.5em;">10/4/71</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">EUGENIA B. LITZURRUA M.D.</span>	
23D. ADDRESS <span style="font-size: 1.5em;">MERCY HOSPITAL</span>							
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">Burial</span>		24B. DATE <span style="font-size: 1.5em;">10-5-71</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.5em;">St. Stanislaus Cemetery</span>		24D. LOCATION City, town, or county (State) <span style="font-size: 1.5em;">Baltimore, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">OCT 6 1971</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. [Signature]</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">Nicholas T. Matthews</span> <span style="font-size: 1.5em;">3920 Eastern Ave., Baltimore, Md.</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <b>71 9307</b>	
BIRTH NO. <b>M-432 71 9307</b>		1. NAME OF DECEASED (Type or Print) <b>MOLTZ, MARGUERITE W.</b>		2. DATE AND HOUR OF DEATH <b>10-5-1971 6 45 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2713</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>701 ST. Johns RD. 21210</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-4-1903</b>	9. AGE (In years last birthday) <b>68</b>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>MR. ADOLPH WEWERKA</b>				14. MOTHER'S MAIDEN NAME <b>RICHTER, MARIE (D)</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-01-5467A</b>		17. INFORMANT <b>Mr. Laurence W. Moltz</b>		ADDRESS <b>Same</b>	
18. <b>712.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>HEART FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIO SCLEROTIC C. VASCULE Disease.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10-4-1971</b> to <b>10-5-1971</b> that (I) (we) last saw the deceased alive on <b>10-5-1971</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Carlos Alberto Battikha</b> DEGREE				23B. DATE SIGNED <b>10.5.1971</b>		23C. PHYSICIAN'S NAME (Type) <b>Carlos Alberto Battikha</b> DEGREE	
23D. ADDRESS <b>Union Memorial Hospital</b>		23E. ATTENDING PHYSICIAN Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-8-71</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 6 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4005 York Road Balto., Md. 21212</b>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 9308

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Ronald Caviness		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 25 Year 71 Hour 9:45 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 So. Balto. Gen. Hospital		3. DATE PRONOUNCED DEAD Month 9 Day 25 Year 71 Hour 9:45 a. M.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 5-1-44		10. AGE (In years lost birthday) 27	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Garland Caviness		14. MOTHER'S MAIDEN NAME Delores Dorn	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		18. SOCIAL SECURITY NO. 216-42-9725	
19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute alcoholic intoxication		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic obstructive pulmonary disease			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 9/25/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-29-71	
24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc.		ADDRESS 1501 East Fort Avenue	



A-425 71

9309

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9309

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Edward J. Alexander		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 3 Year 71 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1346 E. Fort Avenue		3. DATE PRONOUNCED DEAD Month 10 Day 3 Year 71 Hour 8:00 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2401		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE White	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 5-28-18	10. AGE (In years last birthday) 53	E. STREET AND NUMBER 1346 E. Fort Avenue	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Alexander		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman	
15. MOTHER'S MAIDEN NAME Mary Stanke		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II	
17. SOCIAL SECURITY NO. 215-01-2676		18. INFORMANT Mrs. Dorothy Schoeberlein 1334 E. Fort Ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Pulmonary tuberculosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/6/71	
24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1971		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc.		ADDRESS 1501 East Fort Avenue	







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <u>71 9310</u>	
R-360 71 9310					
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<u>Jhon Ritter</u>		<u>October 5th 71 1.10 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u> <u>43</u>			A. STATE <u>MD.</u> B. COUNTY <u>2303</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Male</u>			6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>9/21/11</u>	
<u>Chauffeur</u>		<u>Transfer</u>		9. AGE (in years last birthday) <u>60</u>	
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
<u>Baltimore</u>			<u>USA</u>		
13. FATHER'S NAME <u>Royal A.</u>			14. MOTHER'S MAIDEN NAME <u>Agnes Henley</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
<u>No</u>		<u>213 09 8248</u>		<u>Mary A. Ritter</u>	
18. <u>162-1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Acute GI bleeding</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Coronary of lung</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<u>0</u>				<u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<input type="checkbox"/>					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/28</u> 19 <u>71</u> to <u>10/5</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Hidelfonso M.D.</u>				23B. DATE SIGNED <u>10/3/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Cesar Hidelfonso</u>				23D. ADDRESS <u>South Baltimore General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<u>Burial</u>		<u>10-8-71</u>		<u>Cedar Hill Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<u>OCT 7 1971</u>		<u>John E. ...</u>		<u>130 East ...</u>	
ADDRESS <u>Baltimore, Maryland 21230</u>					



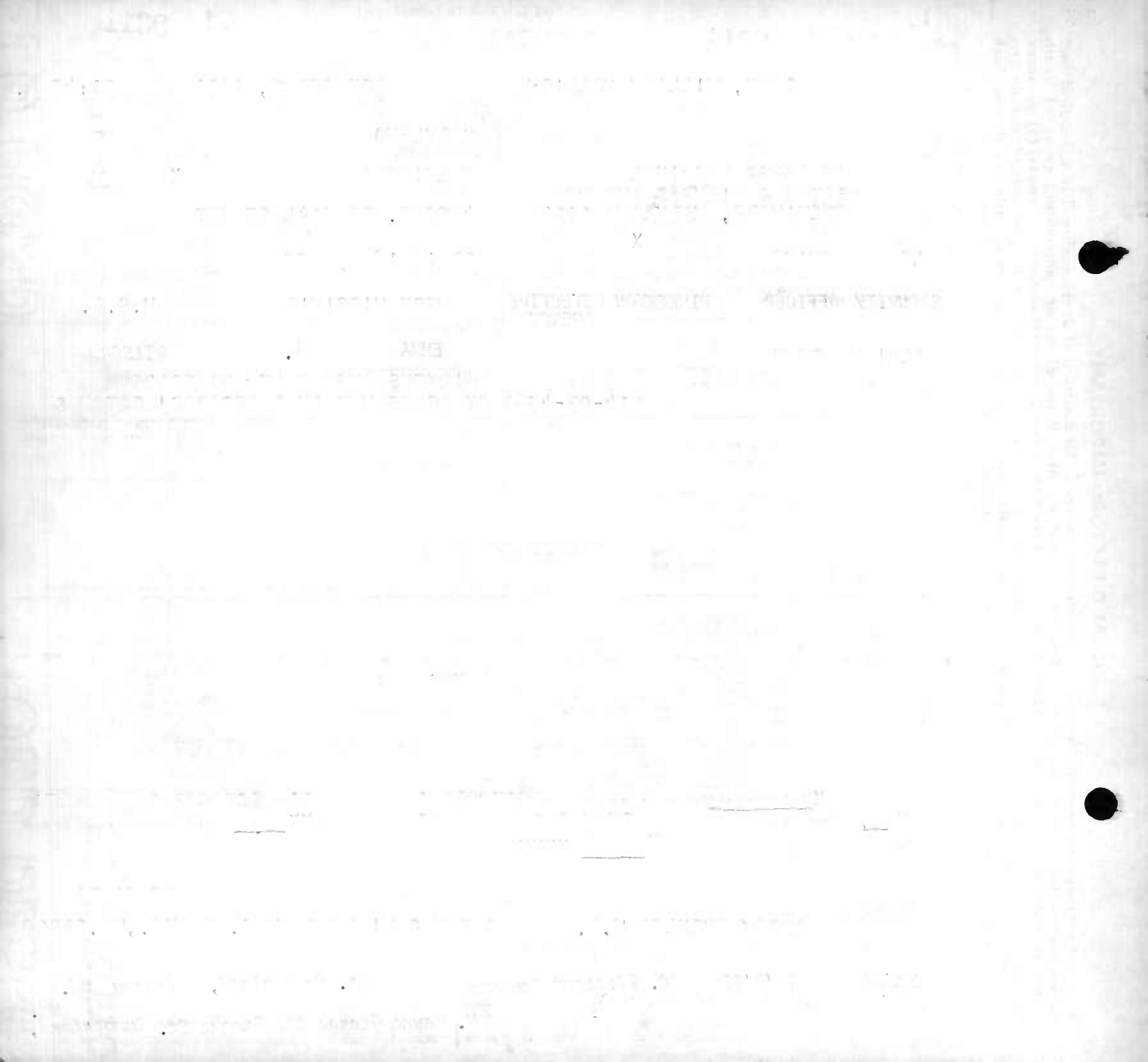
## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

REG. NO. 71 9311

BIRTH NO. <u>C-200 71 9311</u>		1. NAME OF DECEASED Type or Print <u>COOK, WILLIAM HALICK</u>		2. DATE AND HOUR OF DEATH <u>OCTOBER 2, 1971</u> <u>11:45 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>26 34</u>		C. CITY OR TOWN <u>BALTIMORE</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>40 ST AGNES HOSPITAL</u> <u>CATON &amp; WILKENS AVENUES</u> <u>BALTIMORE, MARYLAND 21229</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>4909 E. FEDERAL STREET</u>	
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>07/16/16</u>	9. AGE (in years last birthday) <u>55</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECURITY OFFICER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>PINKERTON DETECTIVE AGENCY</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WILLIAM COOK</u>		14. MOTHER'S MAIDEN NAME <u>EMMA A. WILSON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-07-4581</u>		17. INFORMANT <u>WILKENS AVES BALTO MD 21229</u> <u>ST AGNES HOSPITAL RECORDS' CATON &amp;</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Chronic obstructive</u> <u>60+ Lung Disease</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>OCTOBER 1</u> 19 <u>71</u> to <u>OCTOBER 2</u> 19 <u>71</u> that (X) (we) last saw the deceased alive on <u>OCTOBER 2</u> 19 <u>71</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) view the body after death.					
23A. SIGNATURE <u>Buckler MD</u>				23B. DATE SIGNED <u>10 03 71</u>	
23C. PHYSICIAN'S NAME (Type) <u>LEROY BUCKLER M.D.</u>				23D. ADDRESS <u>CATON &amp; WILKENS AVES. BALTO., MD. 21229</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/5/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Pleasant Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Nr. Cumberland, Allegany Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 7 1971</u>			
25B. NAME OF REGISTRAR <u>W. Wayne George</u>		25C. FUNERAL DIRECTOR <u>202 Greene St. Cumberland, Md.</u>			



<p style="font-size: 24pt; margin: 0;">P-324 71 9312</p> <p style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 24pt; margin: 0;">MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p>		<p style="margin: 0;">REG. NO. 71 9312</p>	
BIRTH NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
JOHN PATCHEL (JOHN R. PATCHEL)		Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		3. DATE PRONOUNCED DEAD	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Month Day Year Hour 10 4 1971 9:30a M.	
5036 E. Eager St. # 21205.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
		A. STATE Md. B. COUNTY 2634	
6. SEX	7. RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years lost birthday)	
July 5, 1955.		16	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Kingston, Pa.		U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
Student		School	
15. MOTHER'S MAIDEN NAME		16. INFORMANT ADDRESS	
Marie P. Patchel		Marie P. Ratliff : 5036 E. Eager St. #5.	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
215-66-2860		Marie P. Ratliff : 5036 E. Eager St. #5.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
Intravenous narcotism			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE	
		DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
Russell S. Fisher, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		10-6-71.	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Cedar Hill Cemetery		Ritchie Highway A.A.Co., Md.	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR	
OCT 7 1971		Charles S. Fisher, M.D.	
25C. FUNERAL DIRECTOR		25D. ADDRESS	
6224 Eastern Ave.		Balto., 21224, Md.	

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WATER RESOURCES

REPORT

NO. 1

1960

WATER RESOURCES

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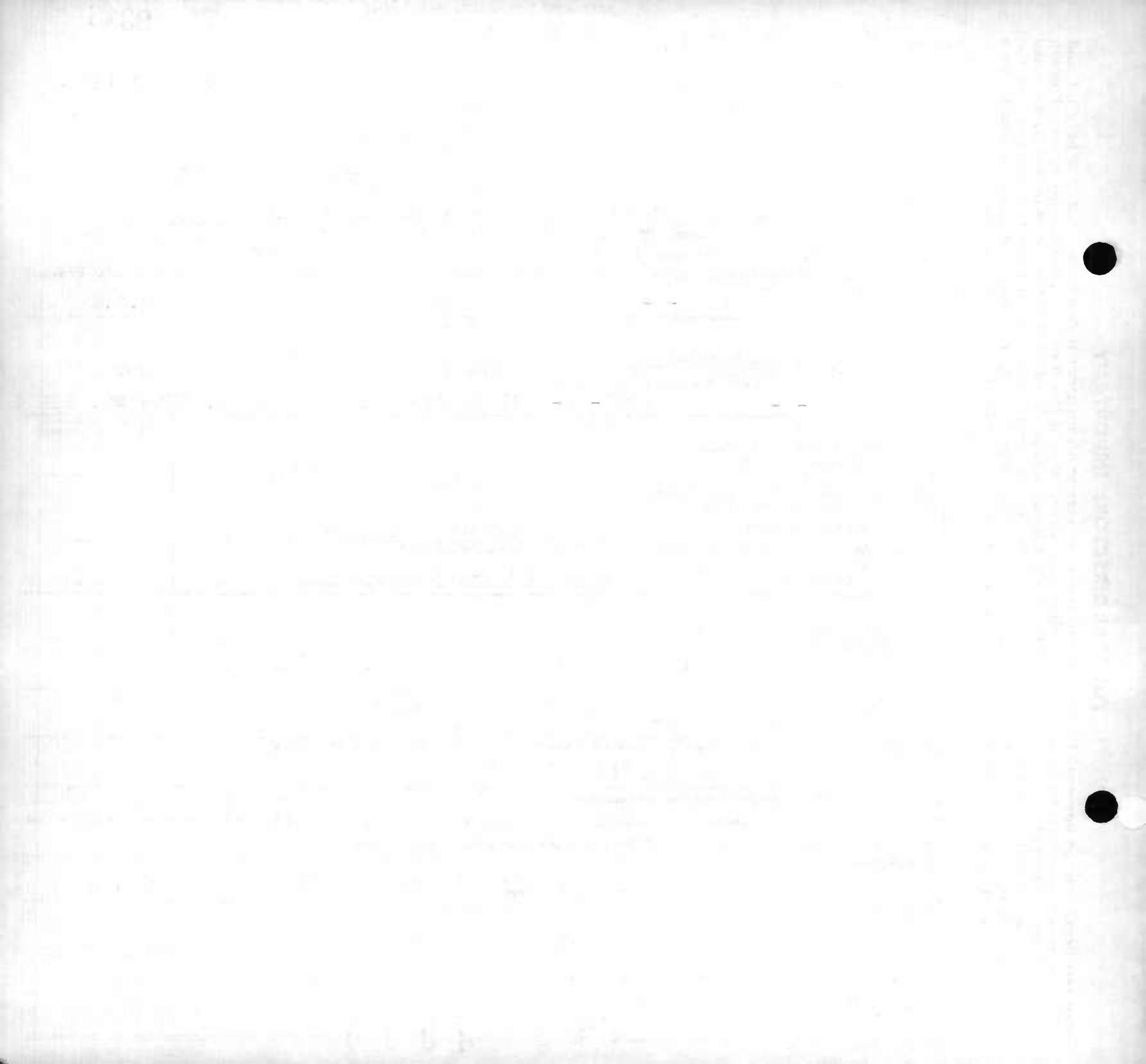
WATER RESOURCES

WATER RESOURCES

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">71 9313</span>	
<b>5-350</b> <b>71 9313</b> <b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">IRMA STEM</span>		<b>CERTIFICATE OF DEATH</b> <b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">OCTOBER 5-71 2:15 A. M.</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <span style="font-size: 1.2em;">44 UNION MEMORIAL HOSPITAL</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">1307</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">BALTIMORE</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">814 W. 37th ST.</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">F</span> <b>6. RACE</b> <span style="font-size: 1.2em;">W</span> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">05-15-12</span> <b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">59</span> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span> <b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">--</span> <b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span> <b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A</span>			
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">EDWARD SULLIVAN</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">MARTHA BOWEN</span>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No --</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">217-26-6638</span> <b>17. INFORMANT</b> <span style="font-size: 1.2em;">Leonard L. Stem</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">814 W. 37th St. 21211</span>			
<b>18. CAUSE OF DEATH</b> <span style="font-size: 1.2em;">I</span> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">(A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">CARDIAC ARREST</span></span> <span style="font-size: 1.2em;">(B) <span style="font-size: 1.2em;">CORONARY INSUFFICIENCY</span></span> <span style="font-size: 1.2em;">(C) <span style="font-size: 1.2em;">ARTERIO SCLEROSIS</span></span>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>   			
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.)		<b>21C. WHERE DID INJURY OCCUR</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">09-07</span> 19 <span style="font-size: 1.2em;">71</span> to <span style="font-size: 1.2em;">10-5</span> 19 <span style="font-size: 1.2em;">71</span></b> <b>that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">10-5</span> 19 <span style="font-size: 1.2em;">71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">[Signature]</span> <span style="float: right;">INTERM DEGREE</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">10/5/71</span>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <span style="font-size: 1.2em;">C. VILDRAN</span> <span style="float: right;">INTERM DEGREE</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">33rd &amp; Calvert ST.</span>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">10/8/71</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Druid Ridge Cemetery</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">OCT 7 1971</span> <b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. ...</span> <b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Donovan Funeral Home</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">3818 Roland Ave</span>			

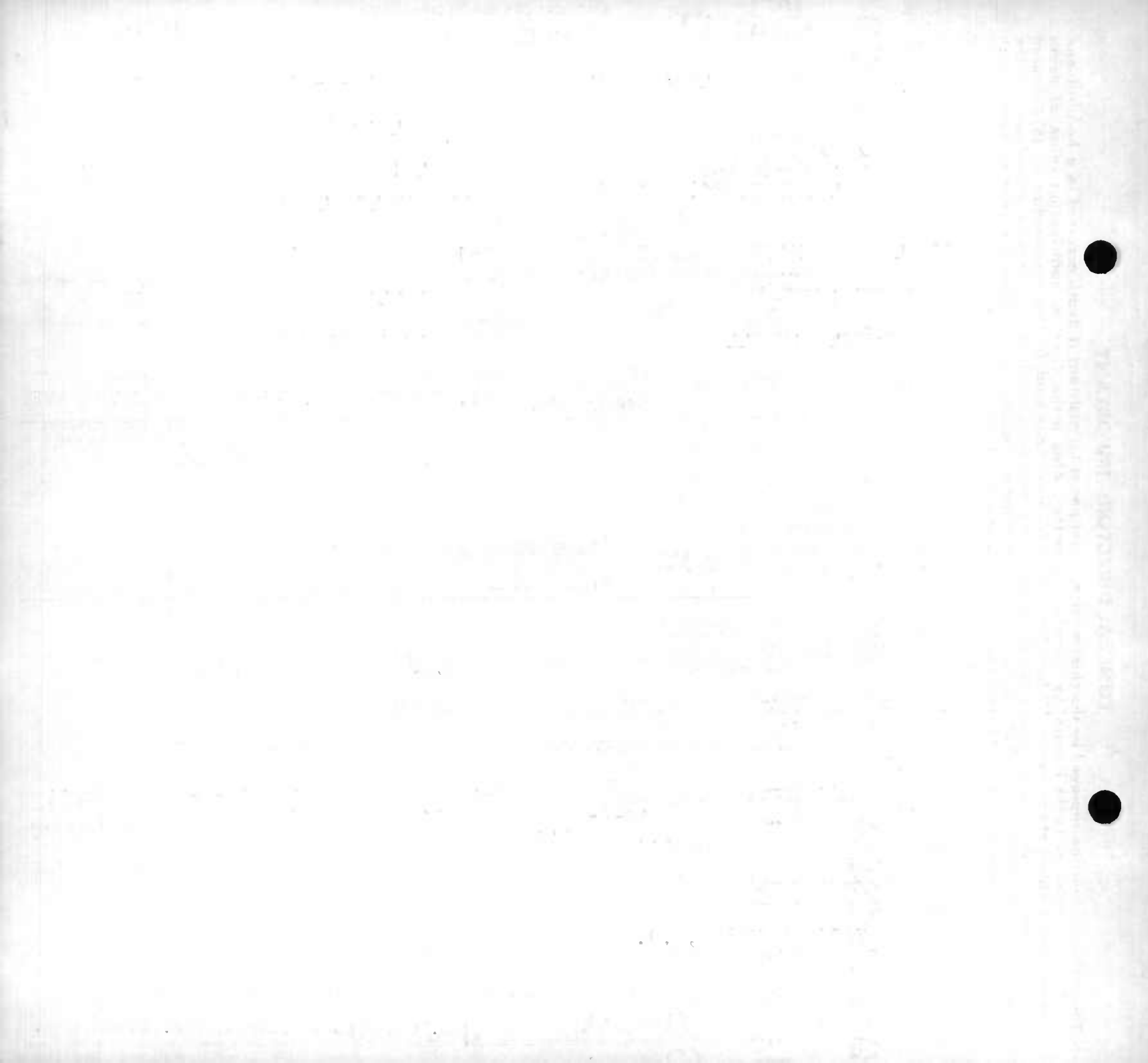




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

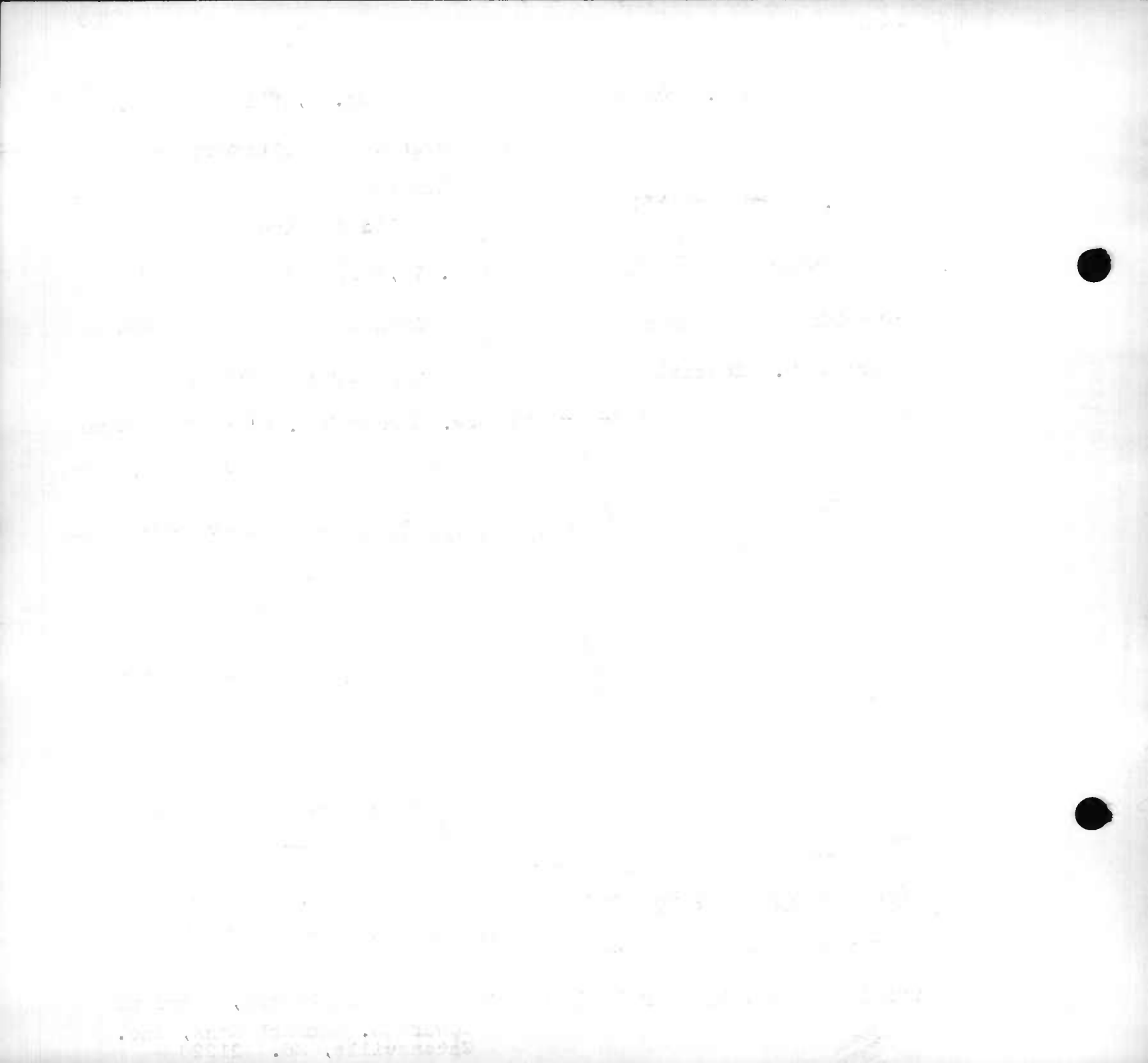
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 71 9314	
BIRTH NO. <b>S-500 71 9314</b>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>SHAWEN CLARA MAY</b>				2. DATE AND HOUR OF DEATH <b>10-5-71 10 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSP 900 CATON AVE. BALTIMORE, MD. 21229</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>BALTIMORE</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>333 HARLEM LANE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-10-80</b>	9. AGE (In years last birthday) <b>91</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>SAMUEL KIMBALL</b>				14. MOTHER'S MAIDEN NAME <b>ANNA BRADFORD</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-22-1227-D</b>		17. INFORMANT ADDRESS <b>ST. AGNES HOSP. RECORD 900 CATON AVE.</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>See Above</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>9-19-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9-19-71</b> to <b>10-5-71</b> that (I) (we) last saw the deceased alive on <b>10-5-71</b> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Tariq Mahmood</i>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>TARIQ MAHMOOD, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-7-71</b>		24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>OCT 7 1971</b>		25B. NAME OF REGISTRAR <i>John E. ...</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Towson, Inc. Towson, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">71 9315</span>
L-520 71 9315				
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		
		Ella M. Lohnes		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Oct. 4, 1971 9 <sup>10</sup> A M.		
40 St. Agnes Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		
		Maryland Baltimore		
		C. CITY OR TOWN D. INSIDE CITY LIMITS?		
		Baltimore YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
		E. STREET AND NUMBER		
		936 Palladi Drive		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan. 17, 1883	88
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife		Home		Virginia
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Lawson T. Winstead		Mary Frances Ashburn		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT
No		213-28-4943		Mrs. Margaret M. O'Keeffe
				Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Cerebro Vascular Accident		
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:		
		Arterio Sclerotic Cardiovascular Disease		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 10/3/71 to 10/4/71 that (I) (we) last saw the deceased alive on 10/2/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
JN Frederick MD				10/5/71
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
JN Frederick MD		1311 Francis Ave Balto Md 21227		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	10/7/71	Moreland Memorial	Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		
OCT 7 1971	Robert E. J. J.	Edward S. MacNabb Sons, Inc.		
		Cottonville, Md. 21228		



**FUNERAL DIRECTOR: IMPORTANT**

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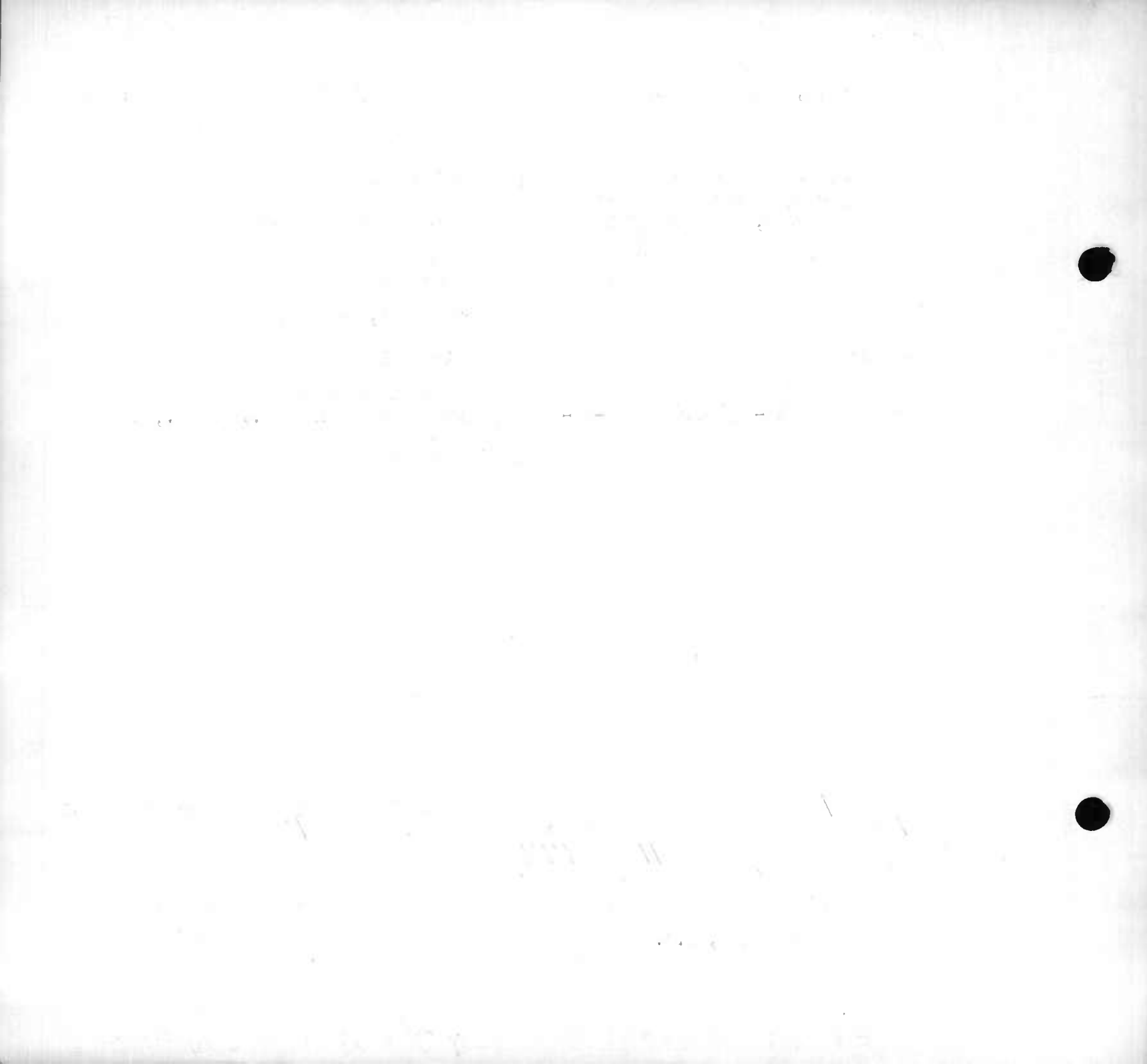
S-351		71 9316		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9316	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Charles Steinbock, Jr.				10/3/71 6:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
St. Agnes Hospital				Md. Baltimore			
900 Caton Ave., Balto. 21229 4/5/72				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
Catonsville				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER				12 Newburg Avenue			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10/4/09	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)	
CPA-self employed				61		Pennsylvania	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?			
Charles Steinbock				USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
Yes WW II				212-07-7383			
17. INFORMANT				ADDRESS			
Mrs. Mary L. Steinbock				Same			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Acute Myocardial Infarction 10-15 minutes			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1955 to Oct 3 1971							
that (I) (we) last saw the deceased alive on 9-19-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
John A. Nesbitt, Jr. M.D.				10-3-71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JOHN A. NESBITT, JR. M.D.				1009 Frederick Rd Baltimore Md 21228			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6 Oct 71		Loudon Park		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
OCT 7 1971		Robert E. Taylor, M.D.		Edward S. MacNabb Sons, Inc. 301 Frederick Rd. Catonsville, Md.			

VS 153 from F.D. on info by wife. SMN

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>71 9317</b>	
BIRTH NO. <b>P-200 71 9317</b>					
1. NAME OF DECEASED (Type or Print) <b>PECK, James Whitney</b>		2. DATE AND HOUR OF DEATH <b>10/4/71 6:00 P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2505</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <b>3907 Pennington Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/22/09</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Ira Peck</b>		14. MOTHER'S MAIDEN NAME <b>Olive Rel</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 6/2/42 - 4/22/44</b>		16. SOCIAL SECURITY NO. <b>217-09-4085</b>		17. INFORMANT <b>VA Hospital Records</b>	
		ADDRESS <b>3900 Loch Raven Blvd., Balto., Md</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>1991 I Malignant Neoplasm, site of origin undetermined</b>		CAUSE OF DEATH <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>September 7th 1971</b> to <b>October 4th 1971</b> that (2) (we) last saw the deceased alive on <b>October 4th 1971</b> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) <b>view</b> the body after death.					
23A. SIGNATURE <b>Alan S. Baker, M.D.</b>				23B. DATE SIGNED <b>5 Oct 1971</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALAN BAKER, M.D.</b>				23D. ADDRESS <b>3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-8-71</b>		24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill</b>	
24D. LOCATION <b>Ritchie Hwy BALTO. MD</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 7 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>		25C. FUNERAL DIRECTOR <b>Hahn Funeral Home</b>	





# FUNERAL DIRECTOR: IMPORTANT

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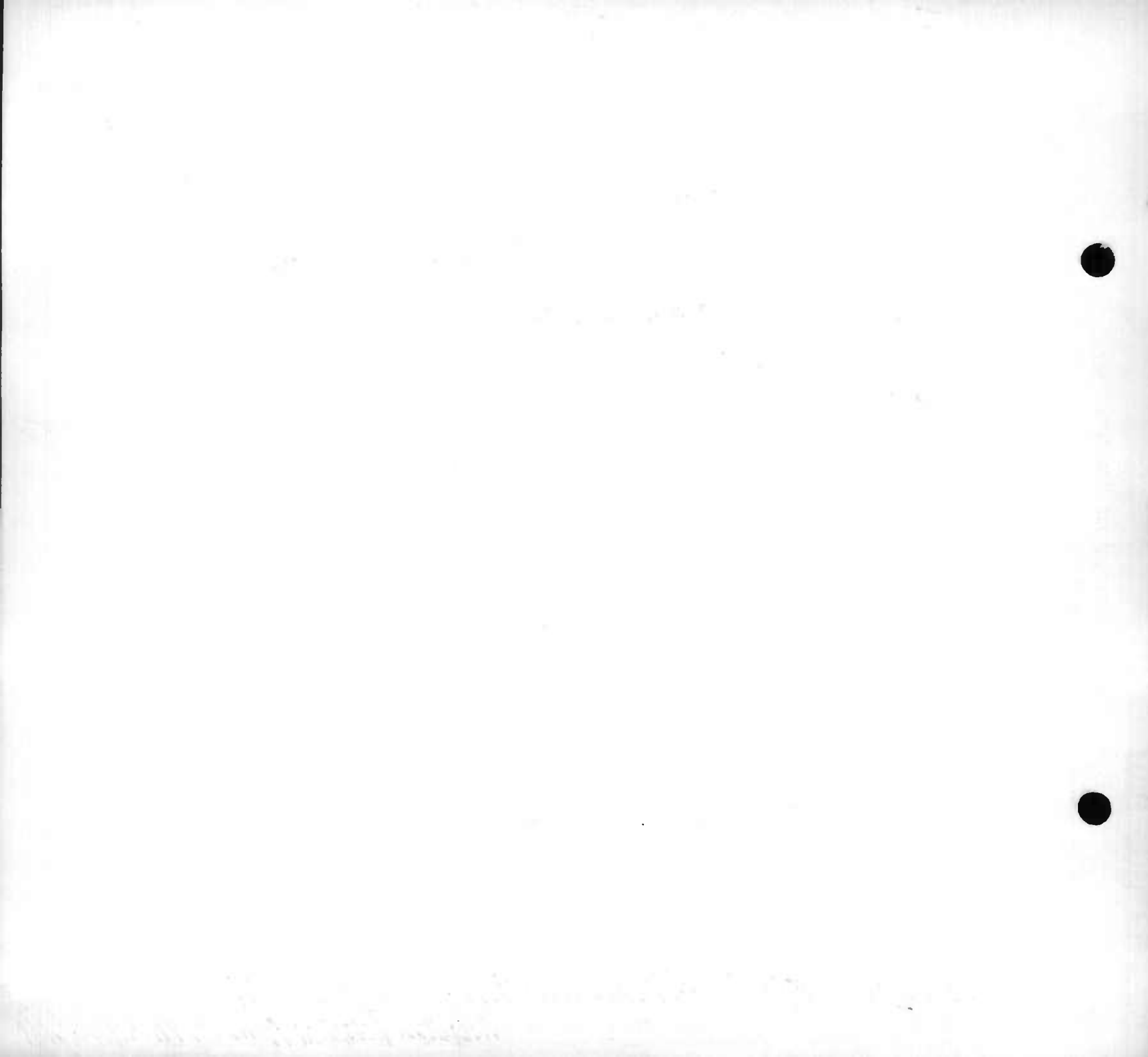
BALTIMORE CITY HEALTH DEPARTMENT				71 9318	
S-520 71 9318				71 9318	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Harry F. SHANKS JR.</i>			2. DATE AND HOUR OF DEATH <i>10-4-1971</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Mem. Hosp.</i>			A. STATE <i>MD</i> B. COUNTY <i>2710</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <i>BALTO</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <i>M.</i> 6. RACE <i>W.</i>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <i>DEC-95</i> 9. AGE (In years last birthday) <i>75</i>			10. UNDER 1 Yr. Months <i>1</i> Days <i>1</i> If Under 24 Hrs. Hours <i>1</i> Min. <i>1</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Locom. Con. Port.</i>			11. BIRTHPLACE (State or foreign country) <i>CHARLES C. MD</i>		
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>JOSEPH SHANKS</i>		
14. MOTHER'S MAIDEN NAME <i>Josephine</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		
16. SOCIAL SECURITY NO. <i>064-071294</i>			17. INFORMANT <i>Ing. S. SHANKS 4916 M. D. Wood Ave</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
A. IMMEDIATE CAUSE <i>CORONARY THROMBOSIS</i> DUE TO, OR AS A CONSEQUENCE OF:					
B. <i>DIABETES MELLITUS</i> DUE TO, OR AS A CONSEQUENCE OF:					
C. _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>9-13-71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>8-26</i> 1970 to <i>9-13</i> 1971 that (I) ( <del>was</del> ) last saw the deceased alive on <i>9-13</i> 1971 and that (in my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>Jerome Gaber</i>				23B. DATE SIGNED <i>10-5-71</i>	
23C. PHYSICIAN'S NAME (Type) <i>JEROME GABER</i>				23D. ADDRESS <i>5706 Bellona Ave Balto Md</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>10/5/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>MT Auburn</i>	
24D. LOCATION (City, town, or county) <i>BALTO MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 7 1971</i>			
25B. NAME OF REGISTRAR <i>Robert E. Gaber, M.D.</i>		25C. FUNERAL DIRECTOR <i>John W. ...</i>			
25D. ADDRESS <i>638 ...</i>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

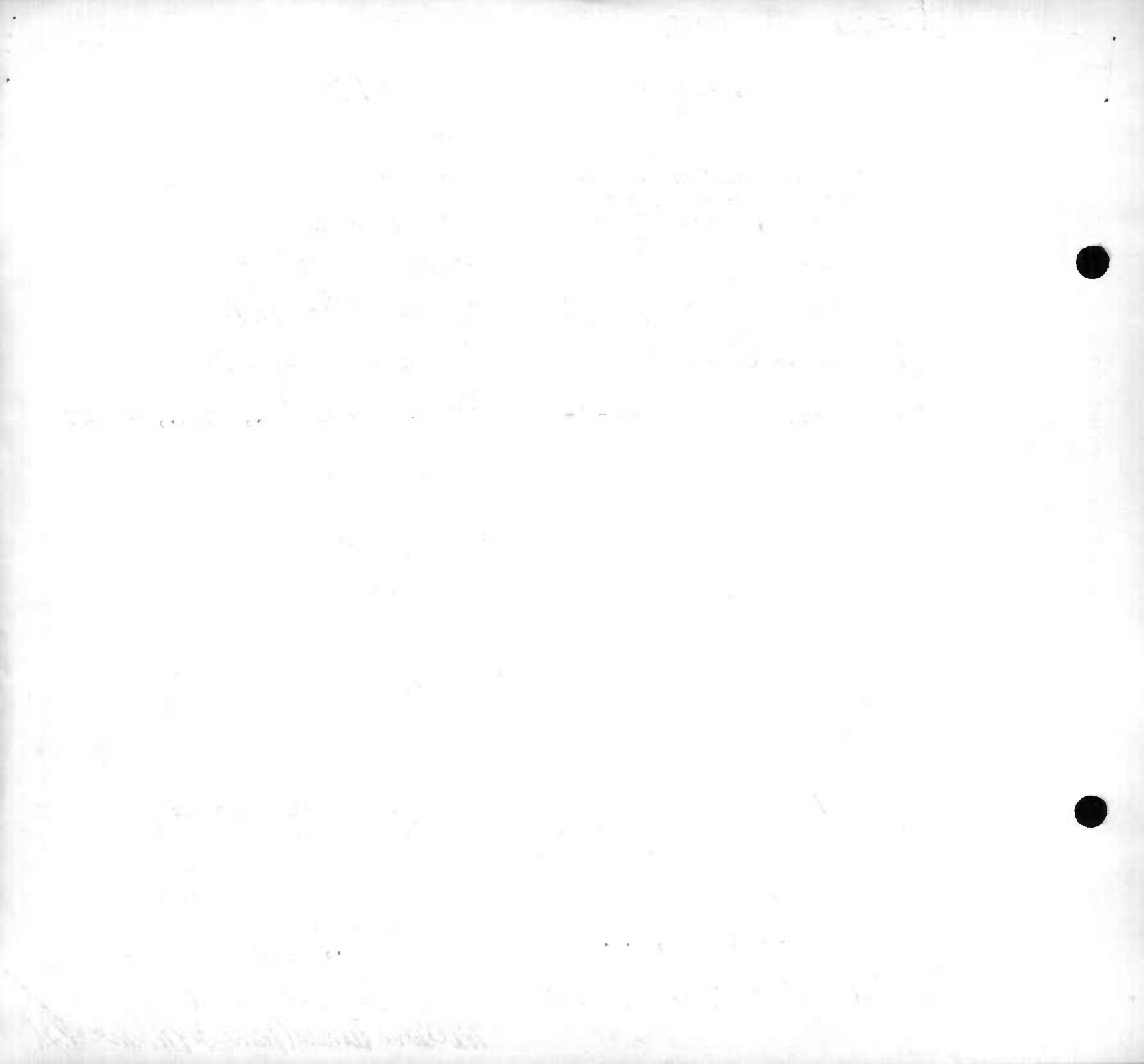
T-600 71 9319				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9319	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>ROBERT TERRY</u>				2. DATE AND HOUR OF DEATH <u>10/5/71</u> <u>8:20 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>4 BON Secours Hosp</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1901</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4 BON Secours Hosp</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>128 N MOUNT STREET</u>			
5. SEX <u>male</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>08-6-1931</u>	9. AGE (in years last birthday) <u>40</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>construction</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Fleming Terry</u>				14. MOTHER'S MAIDEN NAME <u>Lucille HARRIS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>CHART</u>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Lobar pneumonia</u>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>marked fatty liver</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Lobar pneumonia</u>			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>marked fatty liver</u>							
21A. DATE OF OPERATION <u>21</u>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		21C. WHERE DID INJURY OCCUR? <u>he</u>		21D. TIME OF INJURY (APPROX.) <u>19 21</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>he</u>		21C. WHERE DID INJURY OCCUR? <u>he</u>		21D. TIME OF INJURY (APPROX.) <u>19 21</u>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR <u>he</u>					
22. I certify that (I) (this hospital) attended the deceased from <u>between 4</u> 19 <u>21</u> to <u>between 5</u> 19 <u>21</u> that (I) (we) last saw the deceased alive on <u>between 5</u> 19 <u>21</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Rmje Metaronarat</u>				23B. DATE SIGNED <u>October 5th 1921</u>			
23C. PHYSICIAN'S NAME (Type) <u>PIMPA METARONARAT</u>				23D. ADDRESS <u>BON SECOURS HOSPITAL BALTO, MD, 21223</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/4/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Hubert Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 7 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Gaber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u>		ADDRESS <u>3198 Schradel St</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

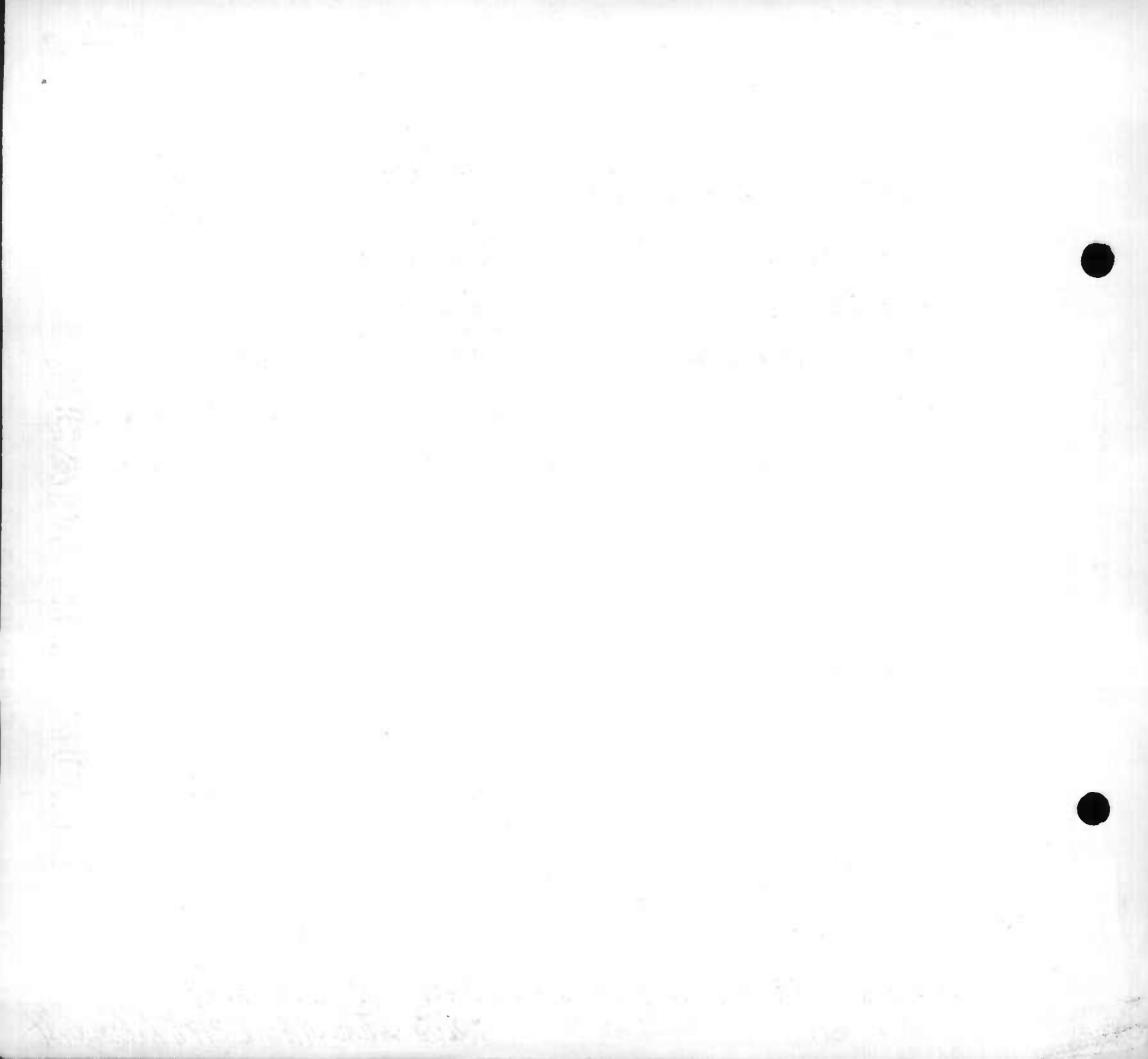
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9320</u>	
J-520 71 9320					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JONES, GARFIELD		10/3/71 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
		A. STATE Maryland B. COUNTY 1601			
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hard Carrier		10B. KIND OF BUSINESS OR INDUSTRY Construction		8. DATE OF BIRTH 6/18/95	
13. FATHER'S NAME Nathan Jones		14. MOTHER'S MAIDEN NAME Fannie Barnett		9. AGE (In years last birthday) 76	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWT		16. SOCIAL SECURITY NO. 214-03-9853		11. BIRTHPLACE (State or foreign country) Calvert Co. Md.	
17. INFORMANT VA Hospital Records		12. CITIZEN OF WHAT COUNTRY? USA			
18. 403 X1		19. CAUSE OF DEATH		ADDRESS 3900 Loch Raven Blvd., Balto., Md 21218	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE hyperkalemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) renal failure		mos.	
		(C) chronic hypertension		yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION no		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED no		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 22th 19 71 to October 4th 19 71 that (I) (we) last saw the deceased alive on October 4th 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE DH McDougal, MD				23B. DATE SIGNED 10/5/71	
23C. PHYSICIAN'S NAME (Type) DAN McDOUGAL, M.D.				23D. ADDRESS 3900 Loch Raven Blvd Balto., Md 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/7/71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION Balto. Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. OCT 7 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR William Funeral Home 398 N. Broadway St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-525 71 9321		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 9321	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>George M. Henson Jr.</u>		2. DATE AND HOUR OF DEATH <u>Oct. 4 1971</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1608</u>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <u>004007 Cranston Ave</u>		C. CITY OR TOWN <u>Ba'to.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>4007 Cranston Ave.</u>		5. SEX <u>Male</u>		6. RACE <u>Colored</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 16 1909</u>		9. AGE (In years last birthday) <u>62</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lift Operator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>A.A. Co. Md.</u>		11. BIRTH PLACE (State or foreign country) <u>May '71</u>	
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <u>Louis Henson</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Jackson</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Evelyn Henson 4007 Cranston</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>May '71</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>7/21/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Myocardial infarction</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>7/10/71</u> 19 to <u>9/13/71</u> 19		that (I) (we) last saw the deceased alive on <u>9/13/71</u> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <u>Richard J. Ottenasek Jr. MD</u>		23B. DATE SIGNED <u>10/6/71</u>		23C. PHYSICIAN'S NAME (Type) <u>66 E. Epps St.</u>	
23D. ADDRESS <u>RICHARD J. OTTENSEK JR. MD</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/8/71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>W.H. Culburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Ba'to. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 7 1971</u>	
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Williams Funeral Home 3199 S. Broadway St.</u>		25D. ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH									
REG. NO. <span style="font-size: 1.5em;">71 9322</span>									
BIRTH NO. <span style="font-size: 1.5em;">L-26371 9322</span>									
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">LOCKHART, Mrs. IVEZ. V.</span>									
2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">10/6/71 6:40 AM</span>									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD									
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">CHURCH HOME &amp; HOSPITAL</span>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">2634</span>							
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">35</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
		E. STREET AND NUMBER <span style="font-size: 1.2em;">1014 ARMSTEAD WAY. - 21205</span>							
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">4-11-93</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">78</span>					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Home</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">VA.</span>					
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">AMERICAN</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">JAMES M. FINCHAM</span>							
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">ANNIE L. JOHNSON</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>							
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">986120806</span>		17. INFORMANT ADDRESS							
18. <span style="font-size: 1.2em;">4-12-71</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Acute Pulmonary Edema. &amp; Ventricular Arrhythmia</span> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Chronic Congestive Heart Failure Complete Atrial Fibrillation</span> (B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">A.C.V. Disease</span> (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">1 hr.</span>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <span style="font-size: 1.2em;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)					
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>							
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <span style="font-size: 1.2em;">G. P. Indolos M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">Oct. 6, 1971</span>					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS							
<span style="font-size: 1.2em;">GERMA P. INDOLOS M.D.</span>		<span style="font-size: 1.2em;">Church Home &amp; Hospital</span>							
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county)	24E. (State)					
<span style="font-size: 1.2em;">BURIAL</span>	<span style="font-size: 1.2em;">10-8-71</span>	<span style="font-size: 1.2em;">BALTO. NATIONAL Cem.</span>	<span style="font-size: 1.2em;">BALTO., MD.</span>						
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS						
<span style="font-size: 1.2em;">OCT 7 - 1971</span>	<span style="font-size: 1.2em;">Robert E. Taylor M.D.</span>	<span style="font-size: 1.2em;">Hartley, Ellen - 2334</span>	<span style="font-size: 1.2em;">Jefferson St.</span>						



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9323</u>
BIRTH NO. <u>2-420</u>		71 9323		
1. NAME OF DECEASED (Type or Print) <u>Joseph C. Glos Sr.</u>		2. DATE AND HOUR OF DEATH <u>Oct. 4<sup>th</sup> 10, 1971</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> FULL NAME OF DECEASED IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>10-27-71</u> <u>141 S. Augusta Ave/</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2008</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>141 S. Augusta Ave.</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 5, 1908</u>	9. AGE (In years last birthday) <u>63</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gas &amp; Electric</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph C. Glos</u>		
14. MOTHER'S MAIDEN NAME <u>Cecilia Voglein</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>218-12-3767</u>		17. INFORMANT <u>Mrs Teresa M. Glos 141 S. Augusta Ave.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Dehydration + Malnutrition</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Carcinoma of large bowel</u> <u>Metastases to liver</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> 19 <u>71</u> to <u>30 Oct</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>30 Oct</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>William J. Ryan M.D.</u>		23B. DATE SIGNED <u>4 Oct 71</u>		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>Oct. 6, 1971</u>	24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 7 - 1971</u>	25B. NAME OF REGISTRAR <u>Robert E. Schab</u>	25C. FUNERAL DIRECTOR <u>G. Truman Schwab</u>		
ADDRESS <u>5151 Balto. National Pike</u>				

Letter from attending Physician 10-27-71 M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">71 9324</span>	
CERTIFICATE OF DEATH					
BIRTH NO. <span style="float: right;">W-42071 9324</span>					
1. NAME OF DECEASED (Type or Print) Willock, Dr. John <i>SCOTT</i>		2. DATE AND HOUR OF DEATH <i>Oct-3-1971 10<sup>10</sup> am, M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Keswick Home For Incurables</i>		A. STATE <i>Baltimore, Md.</i>		B. COUNTY <i>1307</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore, Md.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
91		E. STREET AND NUMBER <i>700 W. 40th. St.</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-12-1877</i>	9. AGE (In years last birthday) <i>93</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Medical Doctor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>M.D.</i>		11. BIRTHPLACE (State or foreign country) <i>Pittsburg, PA.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Samuel Willock</i>			
14. MOTHER'S MAIDEN NAME <i>Linda Haines</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			
16. SOCIAL SECURITY NO. <i>220-44-4847</i>		17. INFORMANT ADDRESS <i>Keswick --- 700 W. 40th. St.</i>			
18. <i>4861</i>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		<i>Pneumonia, left lower lobe</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>① Cerebral arteriosclerosis (senility)</i>		<i>15 years</i>	
		<i>② Squamous carcinoma of face, multiple</i>		<i>5 years</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <i>1/15/62</i> 19__ to <i>10/3/71</i> 19__ that <del>the</del> (we) last saw the deceased alive on <i>10/3/71</i> 19__ and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. <del>the</del> (We) (did) <del>not</del> view the body after death.					
23A. SIGNATURE <i>W.B. Daniels, Jr. M.D.</i>		23B. DATE SIGNED <i>10/3/71</i>		23C. PHYSICIAN'S NAME (Type) <i>W.B. DANIELS, Jr. M.D.</i>	
23D. ADDRESS <i>Keswick 4 St. Baltimore Md 21211</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>			
24B. DATE <i>10/6/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>ALLEGHENY CEM.</i>		24D. LOCATION (City, town, or county) (State) <i>PITTSBURG, PENNA.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 7 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>MITCHELL WIEDEFELD HOME</i>	
				ADDRESS <i>6500 YORK ROAD, BALTO. MD. 21211</i>	

Adm. 1962

Pneumonia, left lower lobe 8 days

② Squamous carcinoma of lung multiple 2 years  
① Cerebral arteriosclerosis (senility) 12 years

NO

10/3/51

1/12/52

10/3/51

10/3/51  
Baltimore Md

X  
Kernick # 24  
W. NO

500 W.

W. B.

Jr.

W. B. DANIELS

W. B. DANIELS, Jr.

C-200 71

BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

9325

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CLARENCE COX		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 4 1971 12:55a M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2719			
6. SEX male	7. RACE negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Aug 11 1917		10. AGE (In years lost birthday) 54	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John S. Cox		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Roxieanna Gatewood		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII	
17. SOCIAL SECURITY NO.		18. INFORMANT Mildred Cox -3801 Primrose Ave., Baltimore, Md	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Front of 2212 Ruskin Ave. 1304		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 10-4-71 ? m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot by assailant.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-7-71	
24C. NAME OF CEMETERY or CREMATORY Locust Cemetery		24D. LOCATION (City, town, or county) (State) Simpsonville, Howard, Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 7 1971		25B. NAME OF REGISTRAR Robert L. Snowden	
25C. FUNERAL DIRECTOR 246 N. Wash. St. Rockville, Md. 20850			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>C-460</u>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>71 9326</u>	
1. NAME OF DECEASED (Type or Print) <u>LOUISE N. CULLER</u>				2. DATE AND HOUR OF DEATH <u>11:55 P.M.</u> <u>19/30/71</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>7 MERCY HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution's residence before admission) A. STATE <u>ABINGDON, MD. (HARFORD CO.)</u> B. COUNTY C. CITY OR TOWN <u>ABINGDON</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>620 W. BAKER AVE</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/8/26</u>	9. AGE (in years last birthday) <u>44</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>C</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EARL WARD</u>				14. MOTHER'S MAIDEN NAME <u>BARBARA LYNCH</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-20-1864</u>		17. INFORMANT <u>Hoyt W. Culke, Abingdon, Md.</u> ADDRESS			
18. <u>4 30 91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Subarachnoid Hemorrhage</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>20 to ruptured aneurysm</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>1 wk.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>9/24</u> 19 <u>71</u> to <u>9/30</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>9/30/71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Charles J. Lancelotta MD</u>				23B. DATE SIGNED <u>10/1/71</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>CHARLES J. LANCELOTTA MD</u>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>10/4/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Bethel Memorial Gardens, Bel Air, Harford, Md.</u>		24D. LOCATION (City, town or county) (State) <u>Harford, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 7 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, Jr.</u>		25C. FUNERAL DIRECTOR <u>Wm. B. Peterson &amp; Son, Towson, Md.</u>		ADDRESS	

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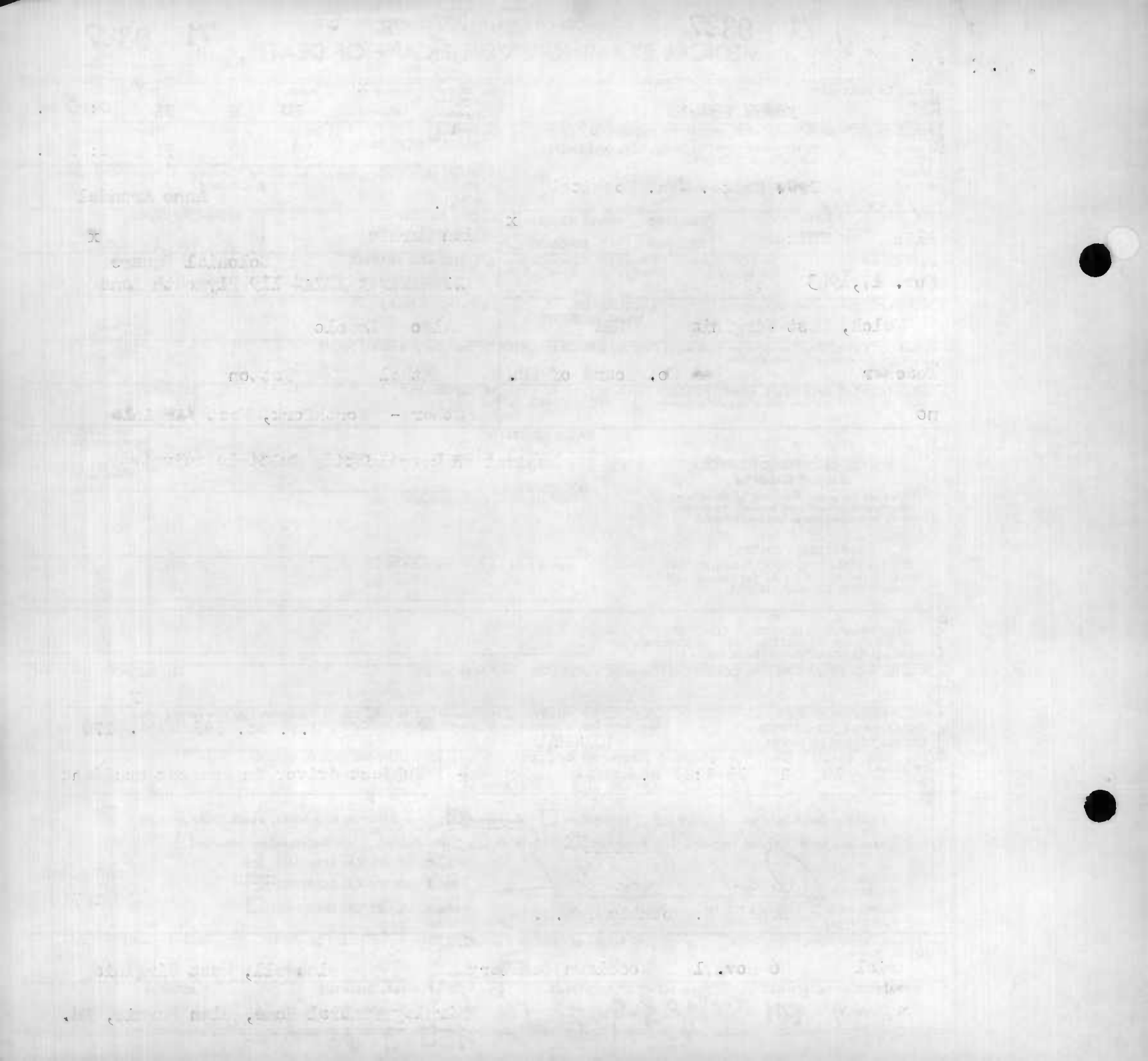
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L-340 71 9327		BALTIMORE CITY HEALTH DEPARTMENT		71 9327	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) James Lodolo				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 10 2 71 2:05 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 So. Balto. Gen. Hospital				3. DATE PRONOUNCED DEAD Month Day Year 10 2 71 2:05 a.m.	
5. USUAL RESIDENCE (Where deceased lived, if Institution; residence before admission) A. STATE Md. B. COUNTY Anne Arundel					
6. SEX male		7. RACE White		C. CITY OR TOWN Glen Burnie D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH Nov. 17, 1943		10. AGE (In years last birthday) 27		E. STREET AND NUMBER Colonial Square 119 Plymouth Lane	
11. BIRTHPLACE (State or foreign country) Welch, West Virginia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Aldo Lodolo	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		14B. KIND OF BUSINESS OR INDUSTRY AA Co. Board of Ed.		15. MOTHER'S MAIDEN NAME Ethel Patton	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Father - Northfork, West Virginia	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Aspiration complicating multiple injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HIGHWAY		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) U.S. Rt. 695 & Md. 170	
22D. TIME OF INJURY (APPROX.) 10 2 71 1:21 a.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject driver in one car accident	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/2/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6 Nov. 71		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Bluewell, West Virginia					
25A. DATE REC'D BY HEALTH DEPT. OCT 7 - 1971		25B. NAME OF REGISTRAR J. E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Kirkley Funeral Home, Glen Burnie, Md.	

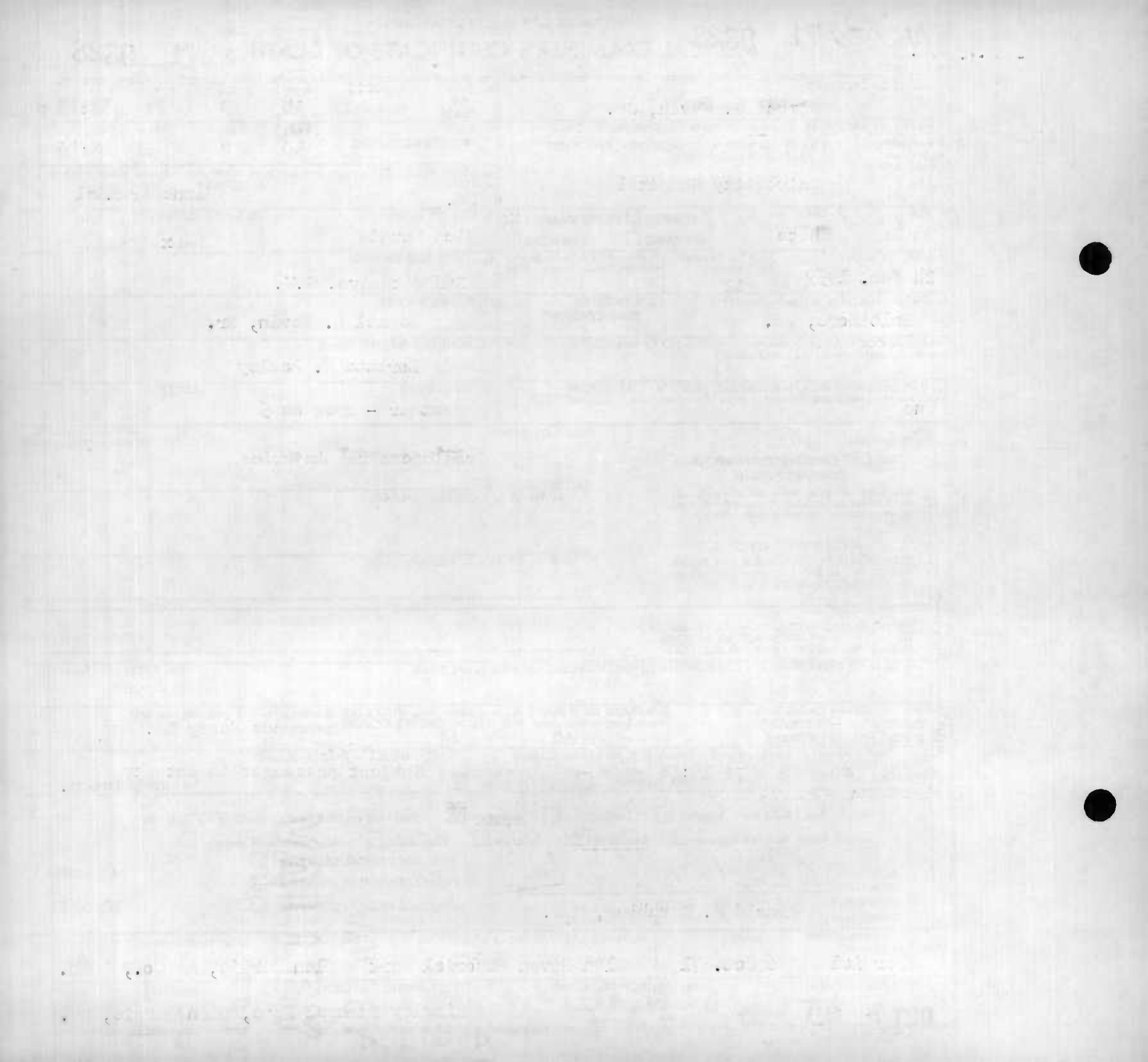


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Samuel R. Nevin, Jr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 2 Year 71 Hour 12:15 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital		3. DATE PRONOUNCED DEAD Month 10 Day 2 Year 71 Hour 12:15 P.M.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Glen Burnie	
9. DATE OF BIRTH 24 Feb. 1959		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 12		E. STREET AND NUMBER 305 4th Ave. S.W.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel R. Nevin, Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Loretta W. Pauley		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Father - same as 5	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Craniocerebral injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ROAD	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Hammonds Ferry Rd. and Dorsey Road		22D. TIME (Month) (Day) (Year) (Hour) (Minute) (Approx.) 10 2 71 10:18 A.M.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject passenger in auto/truck collision.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 10/3/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6 Oct. 71	
24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Park		24D. LOCATION (City, town, or county) (State) Glen Burnie, AA Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 7 - 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR ADDRESS Kirkley Funeral Home, Glen Burnie, Md.			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">71 9329</span>	
<div style="display: flex; justify-content: space-between;"> <span>10-46071 9329</span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Charles A Wheeler		Oct-3-71 9:30 PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
South Baltimore Gen. Hospital		Md Ann Arundel 5200			
FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Glen Burnie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
m		w		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Retired		Paper Hanger		3-4-05 86	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		9. AGE (In years last birthday)	
Baltimore, Md.		USA		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John Wheeler (Dec)		Florence Eslein (Dec)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		218-05-9P38-A		PH's Chart.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Expensive Metastasis and Liver failure			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Liver Lung Cancer			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location!)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 2 1971 to Oct 3 1971 that (I) (we) last saw the deceased alive on Oct 3 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Yung Soo Pang MD				10-3-71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Yung Soo Pang				South Bal Gen. Hospital.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7 Oct. 71		Glen Haven Memorial Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 7 1971		R. E. R. J. L. D. O. O.		Kirkley Funeral Home, Glen Burnie, Md.	

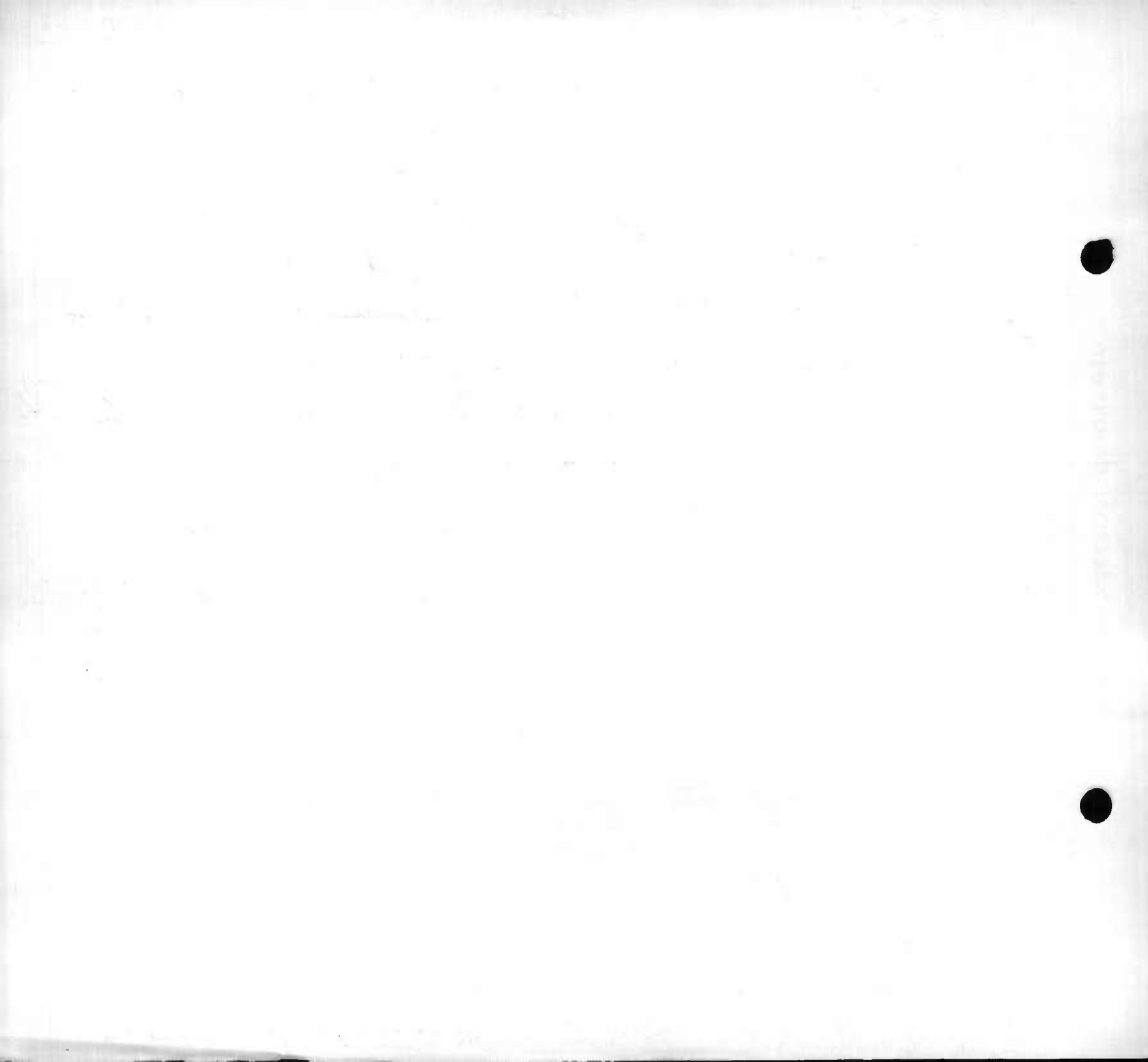




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

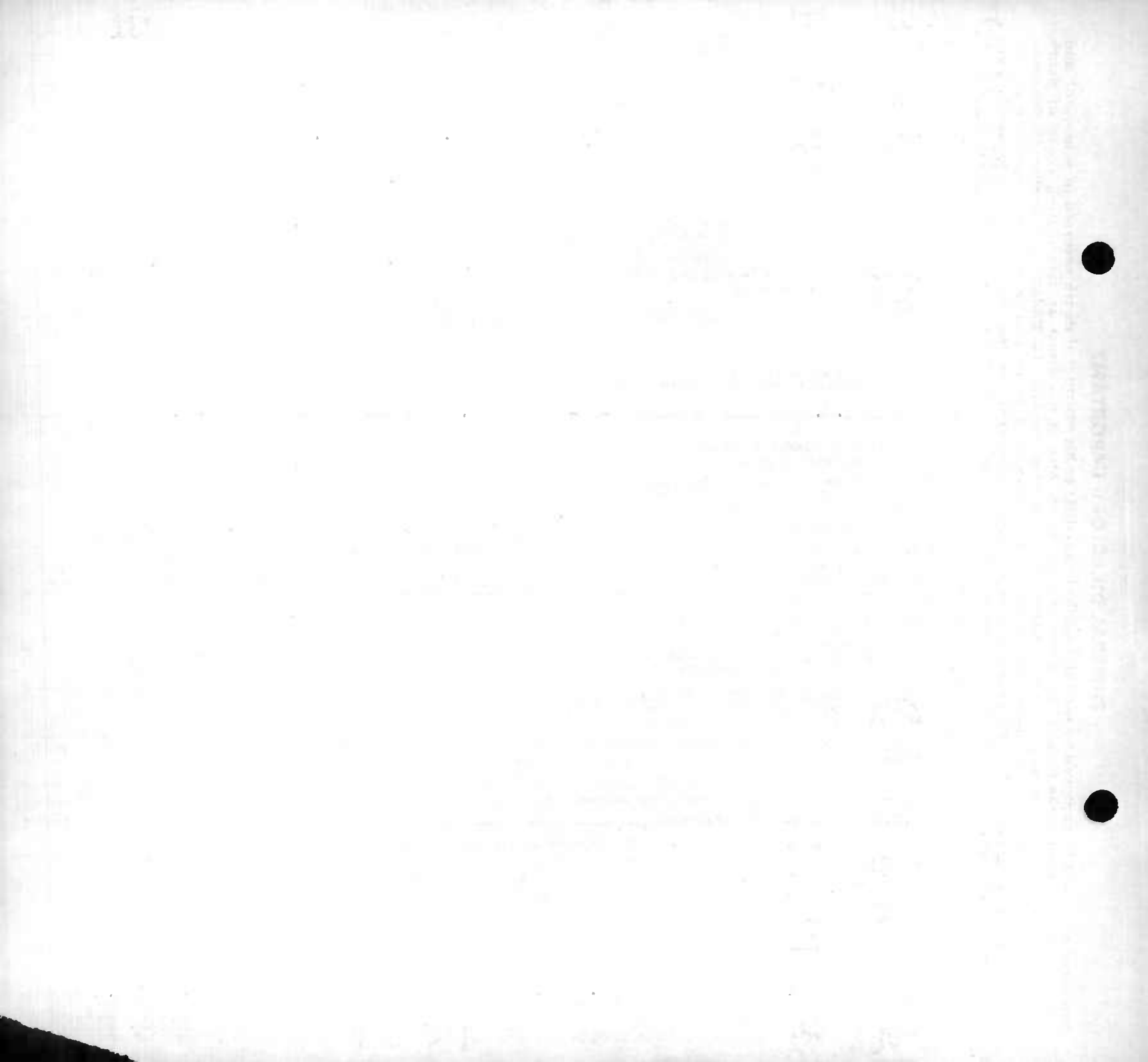
B-650		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9330	
BIRTH NO. 71 9330		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>BROWN, Robert T William</b>		2. DATE AND HOUR OF DEATH <b>October 7, 1971 5:15 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1204</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>North Charles General Hospital</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>327 EAST 21ST STREET</b>			
5. SEX <b>M</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-30-13</b>	9. AGE (In years last birthday) <b>58</b>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MEAT PROCESSING</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MEAT PACKING</b>		11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>	
13. FATHER'S NAME <b>James Brown</b>		14. MOTHER'S MAIDEN NAME <b>Mabel Smith</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-105715</b>		17. INFORMANT <b>Maddie Brown</b>	
18. <b>1621 I</b>		CAUSE OF DEATH		ADDRESS <b>327 E. 21st St</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiorespiratory Arrest</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Severe infection &amp; electrolyte imbalance</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) <b>metastatic bronchogenic CA, Rt. upper lobe -</b>			
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>9-10-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bronchoscopy CA</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, home, factory, street, office bldg, etc.) <b>bronchogenic CA</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 8 1971</b> to <b>Oct. 7 1971</b> that (I) (we) last saw the deceased alive on <b>Oct. 7 1971</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Arturo P. Pangilinan</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>ARTURO P. PANGILINAN</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/11/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>BALTO. CEMETERY</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 8 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Marshall W. Jones Jr.</b>	
25D. LOCATION (City, town, or county) <b>BALTO. Md.</b>		25E. ADDRESS <b>1735-37 Harford Ave.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						CERTIFICATE OF DEATH	REG. NO. <u>1 9331</u>
BIRTH NO. <u>C-450</u>		1. NAME OF DECEASED (Type or Print) <u>Sabatino Cialini</u>		2. DATE AND HOUR OF DEATH <u>10-7-71</u>		7 <sup>50</sup> <u>A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE <u>Md.</u> B. COUNTY <u>BALTO.</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1302 GOUGH ST.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 11 1892</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CRANE OPERATOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>ITALY</u>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>W.W.I</u>			16. SOCIAL SECURITY NO. <u>213-07-1831</u>		17. INFORMANT <u>MRS. CLARA BRUNO</u>		
			ADDRESS <u>1302 GOUGH ST.</u>				
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Septicemia</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <u>Myocardial infarction</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Awayback R.</u>				DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10/11/71</u>		24C. NAME of CEMETERY or CREMATORY <u>NEW CATH. CEM.</u>		24D. LOCATION (City, town, or county) (State) <u>OLD FREDERICK RD. BALTO. Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 8 - 1971</u>		25B. NAME OF REGISTRAR <u>Paula R. ...</u>		25C. FUNERAL DIRECTOR <u>James M. ...</u>		ADDRESS <u>322 S. HIGH</u>	



# FUNERAL DIRECTOR: IMPORTANT

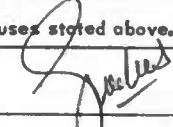
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

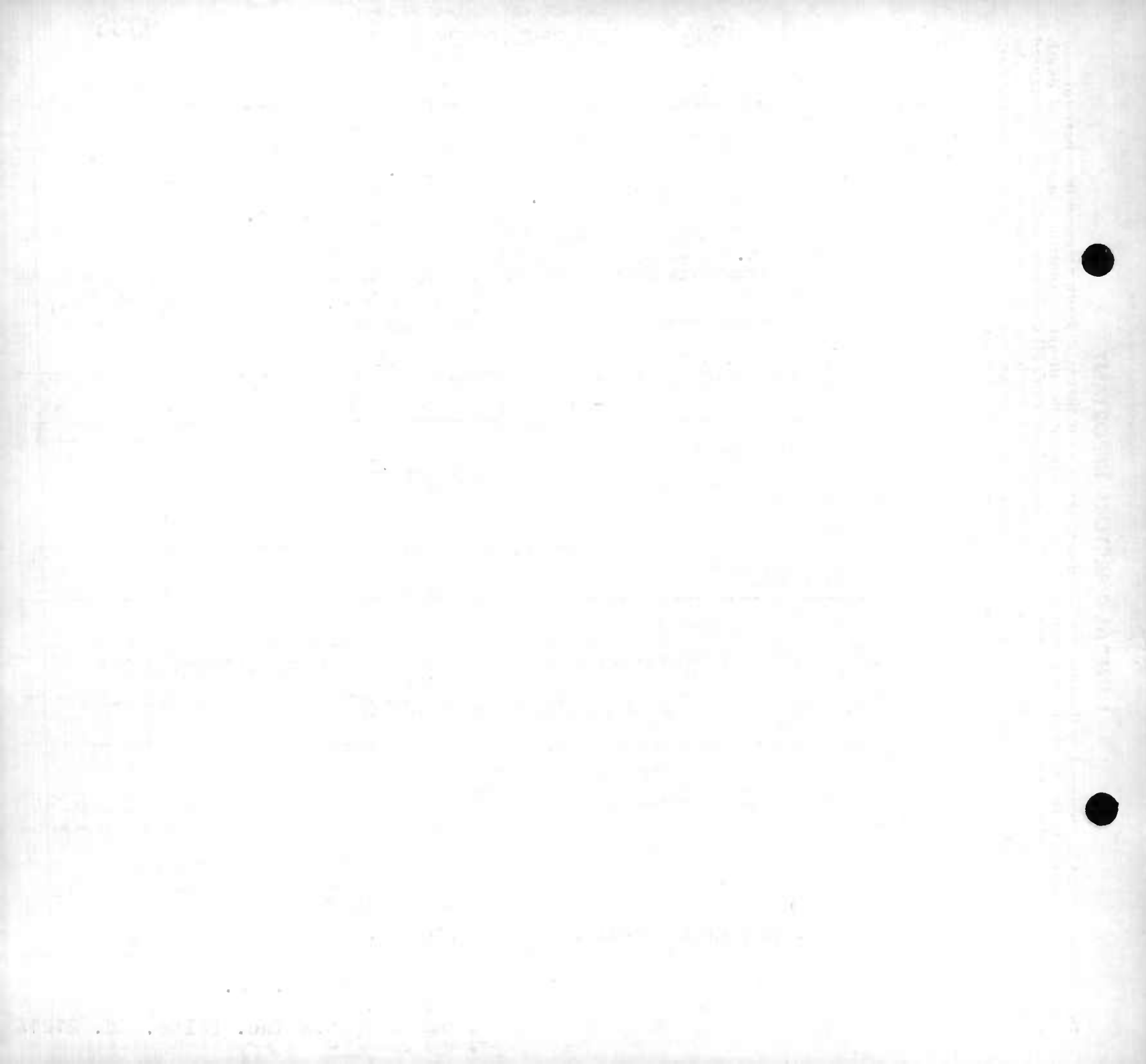
BIRTH NO. <u>W-450 71 9332</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 9332</u>	
1. NAME OF DECEASED (Type or Print) <u>DAISY M. WHALEN</u>			2. DATE AND HOUR OF DEATH <u>OCT. 5 1971 1:45 P. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Ashburton Nursing Home, Inc.</u> <u>3520 North Hilton Rd.</u> <u>Baltimore, Md. 21215</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1511</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3520 North Hilton Road</u>		
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-03</u>	9. AGE in years (last birthday) <u>68</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>Md.</u>		
13. FATHER'S NAME <u>George W. Mobley</u>			14. MOTHER'S MAIDEN NAME <u>Mandy C. Taylor</u>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>220-54-8287</u>		
17. INFORMANT <u>Severn, Maryland</u> <u>George W. Whalen - son - Box 39F2 Virginia Ave.</u>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Bronchopneumonia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Cerebral Thrombosis</u>		
19. DATE OF OPERATION <u>0</u>			20. AUTOPSY? (Yes or No) <u>NO</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR		
22. I certify that (I) (this hospital) attended the deceased from <u>July 20 1965</u> to <u>Oct. 5 1971</u> that (I) (we) last saw the deceased alive on <u>Sept 30 1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Abraham B. Hurwitz MD</u>			23B. DATE SIGNED <u>Oct. 5, 1971</u>		
23C. PHYSICIAN'S NAME (Type) <u>ABRAHAM B. HURWITZ MD</u>			23D. ADDRESS <u>7501 Liberty Rd, Baltimore Md.</u>		
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>10/8/71</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>			24D. LOCATION (City, town, or county) (State) <u>Gaithersburg Montgomery Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 8 1971</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		
25C. FUNERAL DIRECTOR <u>Tyson, Wheeler Funeral Home 1331 Rock. Pike</u>			25D. ADDRESS <u>Rockville, Maryland</u>		

admitted 1965

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9333</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">S-536</span> <span style="font-size: 1.5em;">71 9333</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SNYDER, MARY A.		10-3-1971 5.25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 44 UMH Union Memorial Hosp.			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
			C. CITY OR TOWN Balto.		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 1809 Hillenwood Rd. 21239		
5. SEX Female	6. RACE W Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-26-89	9. AGE (in years last birthday) 82	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) EUROPE Ukraine	
12. CITIZEN OF WHAT COUNTRY? AMERICAN USA		13. FATHER'S NAME Samuel Niedzwiecki		14. MOTHER'S MAIDEN NAME Helen	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-7967A		17. INFORMANT Walter F Fial	
				ADDRESS 21239 SON 1929 WOOD BOURNE AVE.	
18. 427.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE C.H.F. DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19. 427.01 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-2-1971 to 10-3-1971 that (I) (we) last saw the deceased alive on 10-3-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 10-3-1971	
23C. PHYSICIAN'S NAME (Type) GHASSAN NAHAS				23D. ADDRESS UMH - BALTIMORE - Md 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-7-71		24C. NAME of CEMETERY or CREMATORY St Stanislaus Cem	
24D. LOCATION Balto. Md.		24E. DATE REC'D BY HEALTH DEPT. OCT 8 1971		24F. NAME OF REGISTRAR Robert E. Taylor M.D.	
24G. FUNERAL DIRECTOR Leonard J. Ruck Inc.		24H. ADDRESS Balto. Md. 21214		24I. DATE 10-3-1971	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

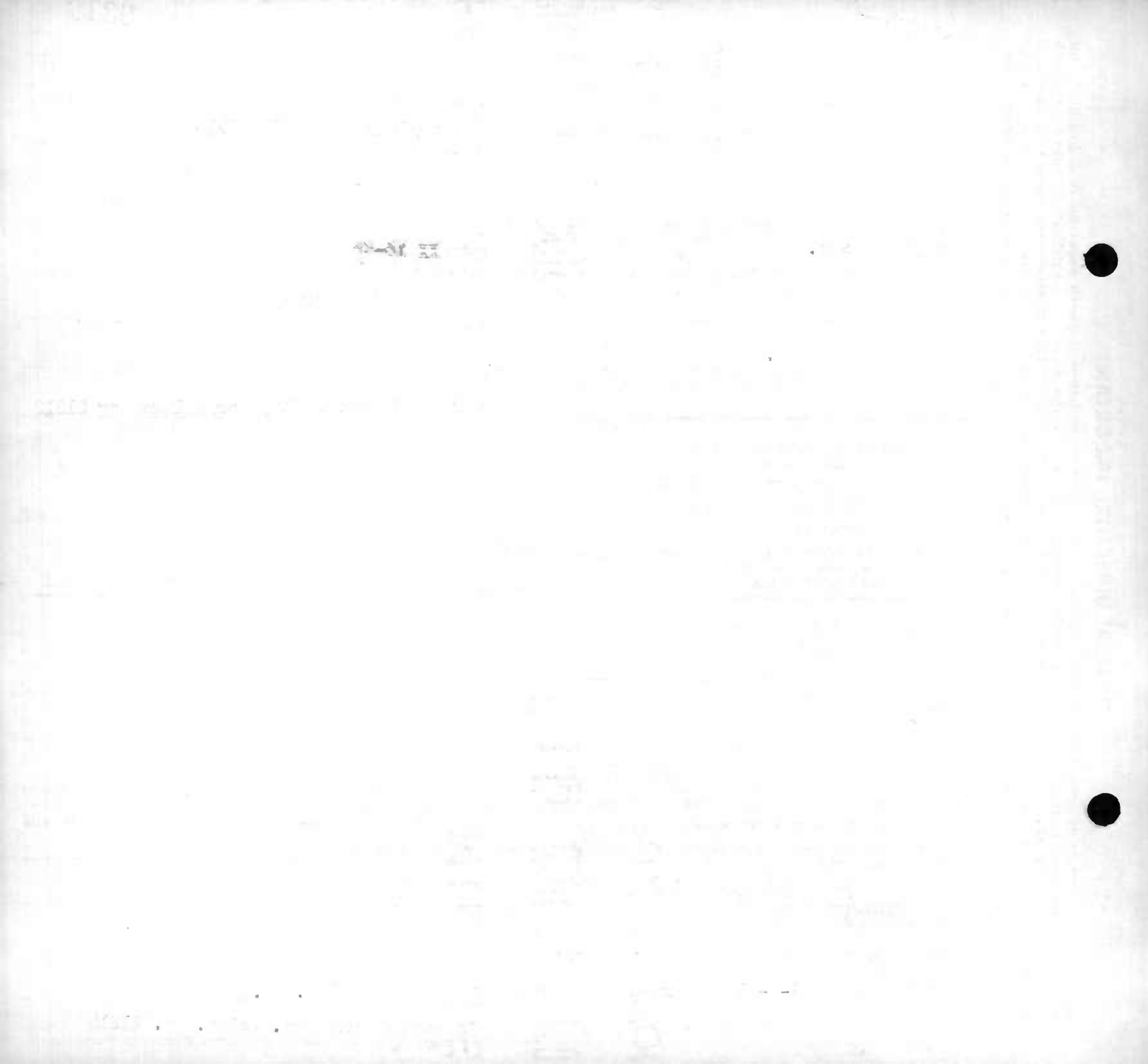
B-55071 9334				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9334	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>BOWMAN, MARY L.</b>				2. DATE AND HOUR OF DEATH <b>10/4/71 11 50 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND General Hosp.</b>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <b>Maryland</b>		B. COUNTY <b>2735</b>	
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3407 Rosalie Ave</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/24/27</b>		9. AGE (in years last birthday) <b>47</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H Hannahs</b>				14. MOTHER'S MAIDEN NAME <b>Catherine C Strwart</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-12-3489</b>		17. INFORMANT <b>Mr John A Bowman</b>		ADDRESS <b>Same</b>	
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>BRONCALGENIC CA REWOMA, UNDIFFERENTIATED</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH <b>BRONCALGENIC CA REWOMA, UNDIFFERENTIATED</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/21/71</b> 19 <b>71</b> to <b>10/4/71</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>10/4/71</b> 19 <b>71</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Donald H. Nisco, M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/4/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Donald H. Nisco, M.D.</b>		23D. ADDRESS <b>M.G.H.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/25/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Green Valley</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25. DATE RECD BY HEALTH DEPT. <b>OCT 8 1971</b>		25B. NAME OF REGISTRAR <b>Robert J. Ruck, Jr.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		ADDRESS <b>Baltimore, Md</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 9335		71 9335	
L-125				71 9335		71 9335	
BIRTH NO.				71 9335		71 9335	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Mary Katherine Lipscomb				Oct. 5, 1971, 7:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Union Memorial Hosp.				Maryland city Baltimore			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				5301 Springlake Way 21212			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Min.
Female	Cauc	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10/5/71	11			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Student						N. J. New Jersey	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles S. Lipscomb				Mary Webster			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no						Charles S Lipscomb 5103 Springlake Way 21212	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		1 wk.	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:		since birth	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				no			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (the hospital) attended the deceased from 9-16-71 to 10-5-71 that (I) (we) last saw the deceased alive on 10-5-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
J. Roberts, MD				10-5-71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				Union Memorial Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Cremation		9-6-71		Greenmount Crematory		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 8 - 1971		Leonard J. Ruck Inc.		Balto. Md.		21214	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9336</u>	
BIRTH NO. <u>B-650 71 9336</u>				<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <u>NETTIE J. BROWN</u>			2. DATE AND HOUR OF DEATH <u>Oct 6, 1971</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> HOSPITAL OR INSTITUTION <u>10-27-71</u> ADDRESS OR LOCATION <u>2043 Ramblewood Rd.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>275-8</u>		
5. SEX <u>F</u>			6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>May 25, 1882</u>			9. AGE (in years last birthday) <u>89</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Joseph Fager</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Tatum</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>213-09-68440</u>		17. (INFORMANT) <u>Mrs James Fitzgerald</u> ADDRESS <u>SAME ABOVE</u>
18. <u>412.31</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>March</u> 19 <u>52</u> to <u>Oct 6</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>Oct 4</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <u>Conrad Richter</u> DEGREE <u>Attending Phys.</u> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> 23B. DATE SIGNED <u>10/6/71</u> 23C. PHYSICIAN'S NAME (Type) <u>Dr Conrad Richter</u> 23D. ADDRESS <u>3128 Harford Rd. Baltimore Md</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>10-9-71</u> 24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u> 24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u> 25A. DATE REC'D BY HEALTH DEPT. <u>OCT 8 1971</u> 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> 25C. FUNERAL DIRECTOR <u>Leonard J. Duck Inc.</u> ADDRESS <u>Balto. Md. 21214</u>					

VS 153

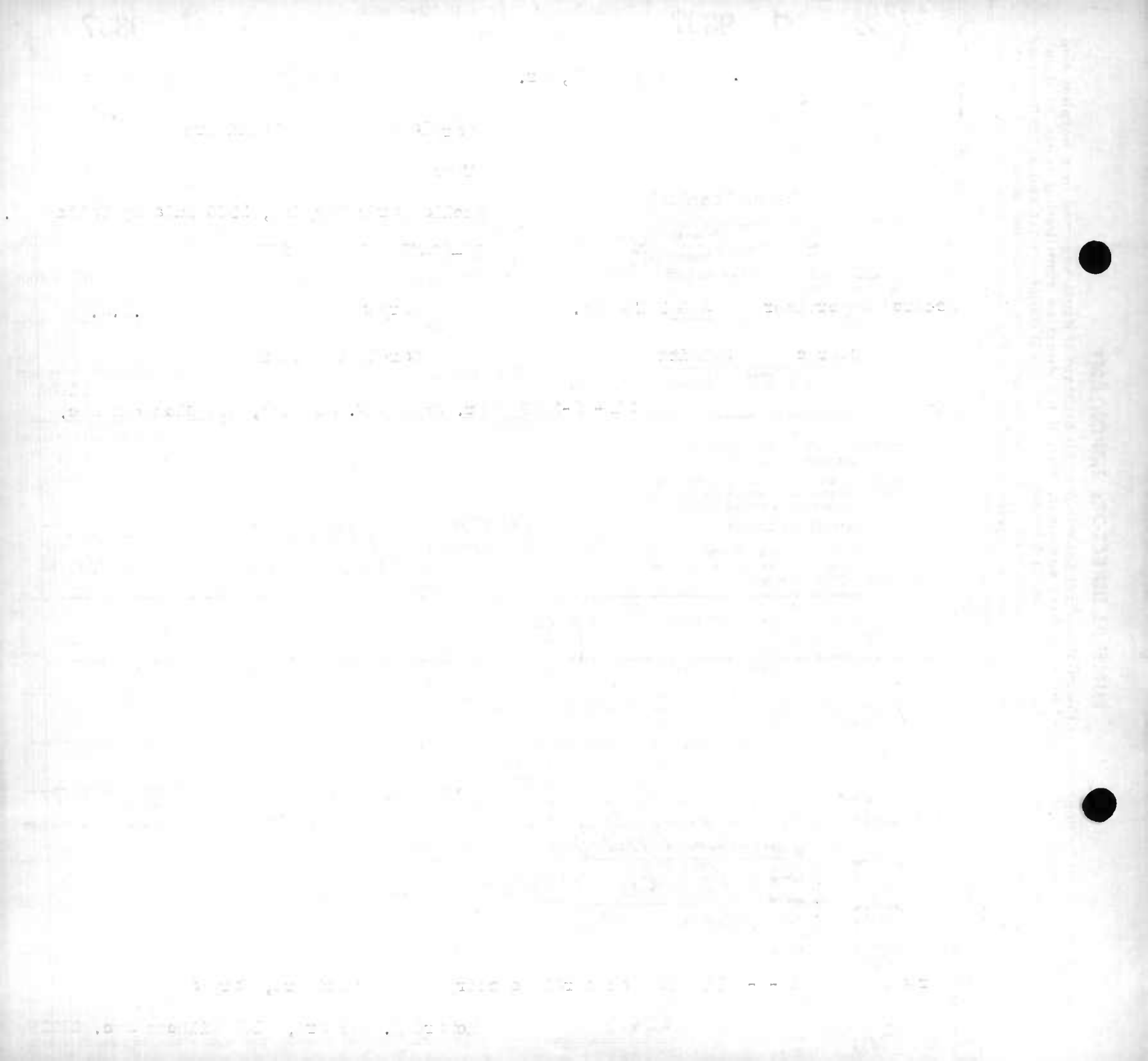
10-27-71

M. H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9337</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">S-530 71 9337</span> </div>					
<div style="display: flex; justify-content: space-between;"> <div> <b>BIRTH NO.</b>  <b>1. NAME OF DECEASED</b>                      (Type or Print) <span style="font-size: 1.2em;">Louis R. Schmitt, Sr.</span> </div> <div> <b>2. DATE AND HOUR OF DEATH</b>  <span style="font-size: 1.2em;">5:28 am 10/5/71</span> M.                 </div> </div>					
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>  <span style="font-size: 1.5em;">37</span> <span style="font-size: 1.2em;">Mercy Hospital</span> </div> <div> <b>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b> </div> </div>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution residence before admission) <div style="display: flex; justify-content: space-between;"> <div> <b>A. STATE</b>  <span style="font-size: 1.2em;">Maryland</span> </div> <div> <b>B. COUNTY</b>  <span style="font-size: 1.2em;">Baltimore</span> </div> </div>		
<b>5. SEX</b> <span style="font-size: 1.2em;">M</span>			<b>6. RACE</b> <span style="font-size: 1.2em;">W</span>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired Supervisor</span>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">A &amp; P Tea Co.</span>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">11-22-98</span>
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">George Schmitt</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Caroline Heidrick</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>			<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">215-05-2977</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mr. Joseph F. Schmitt, 404 Glenmont Ave.</span>
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <span style="font-size: 1.5em;">cardiac arrest</span> DUE TO, OR AS A CONSEQUENCE OF: (B) <span style="font-size: 1.5em;">SHOCK, hypovolemic</span> DUE TO, OR AS A CONSEQUENCE OF: (C) <span style="font-size: 1.5em;">SEPTICEMIA</span>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.5em;">10'</span> <span style="font-size: 1.5em;">4 hrs.</span> <span style="font-size: 1.5em;">1 day</span>
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <span style="font-size: 1.5em;">GASTRECTOMY</span>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">10/1/71</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">Zollinger-Ellison synd.</span>		<b>20A. AUTOPSY</b> (Yes or No) <span style="font-size: 1.2em;">yes</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">10/4/71</span> 19 <span style="font-size: 1.2em;">10/5</span> 19 <span style="font-size: 1.2em;">71</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">10/5</span> 19 <span style="font-size: 1.2em;">71</span> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">[Signature] M.D.</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">10/5/71</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">JUAN M. PARDO</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">MERCY HOSPITAL</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">10-8-1971</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">New Cathedral Cemetery</span>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">OCT 8 - 1971</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. [Signature]</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Howard H. Hubbard</span>	
<b>ADDRESS</b> <span style="font-size: 1.2em;">4107 Wilkens Ave. 21229</span>					





1

4-520 9338 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

71 9338

BIRTH NO.

1. NAME OF DECEASED  
 (Type or Print)

Charles Edward Haines

2. DATE  
 OF DEATH

Known ☒ Estimated ☐

Month 10 Day 2 Year 71

Hour 10:30 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland General Hospital

3. DATE PRONOUNCED DEAD

Month 10 Day 2 Year 71

Hour 10:30 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
 A. STATE B. COUNTY

Md.

1101

6. SEX

male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

June 4, 1911

10. AGE (In years last birthday)

60

11. Under 1 Yr. 12. Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

714 St. Paul St. - Apt. 4

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Herman F. Haines

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Driver - Limousine - Airport

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Molly Kelly

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War II

17. SOCIAL SECURITY NO.

218-10-1918

18. INFORMANT

Mr. Roy F. Haines 3836 Brownhill Rd. 21133

ADDRESS

19.

412.41

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/3/71

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/7/1971

24C. NAME OF CEMETERY or CREMATORY

Woodlawn Cemetery

24D. LOCATION (City, town, or county) (State)

Woodlawn, Maryland

25A. DATE REC'D BY HEALTH DEPT.

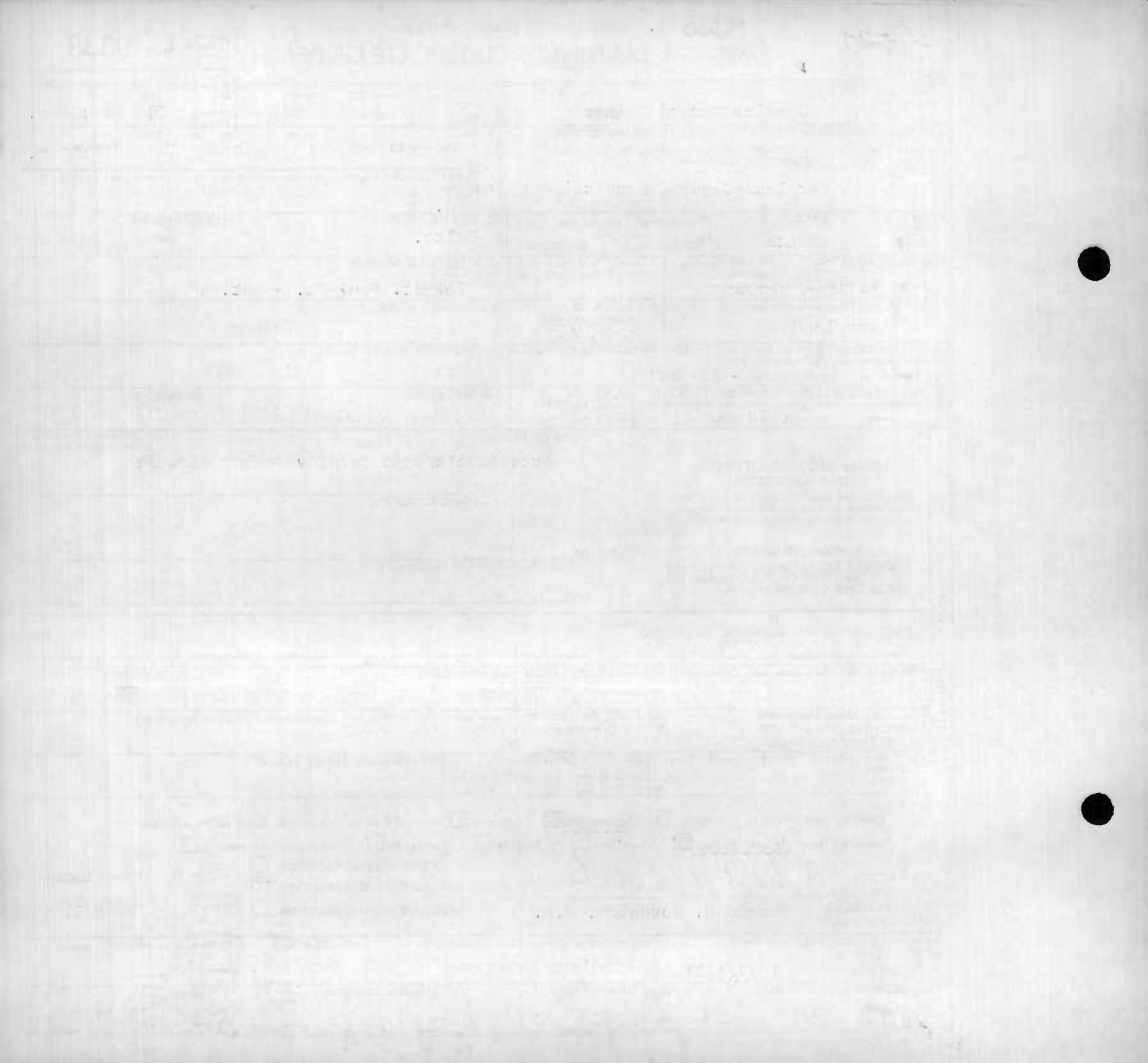
OCT 8 - 1971

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR 21133

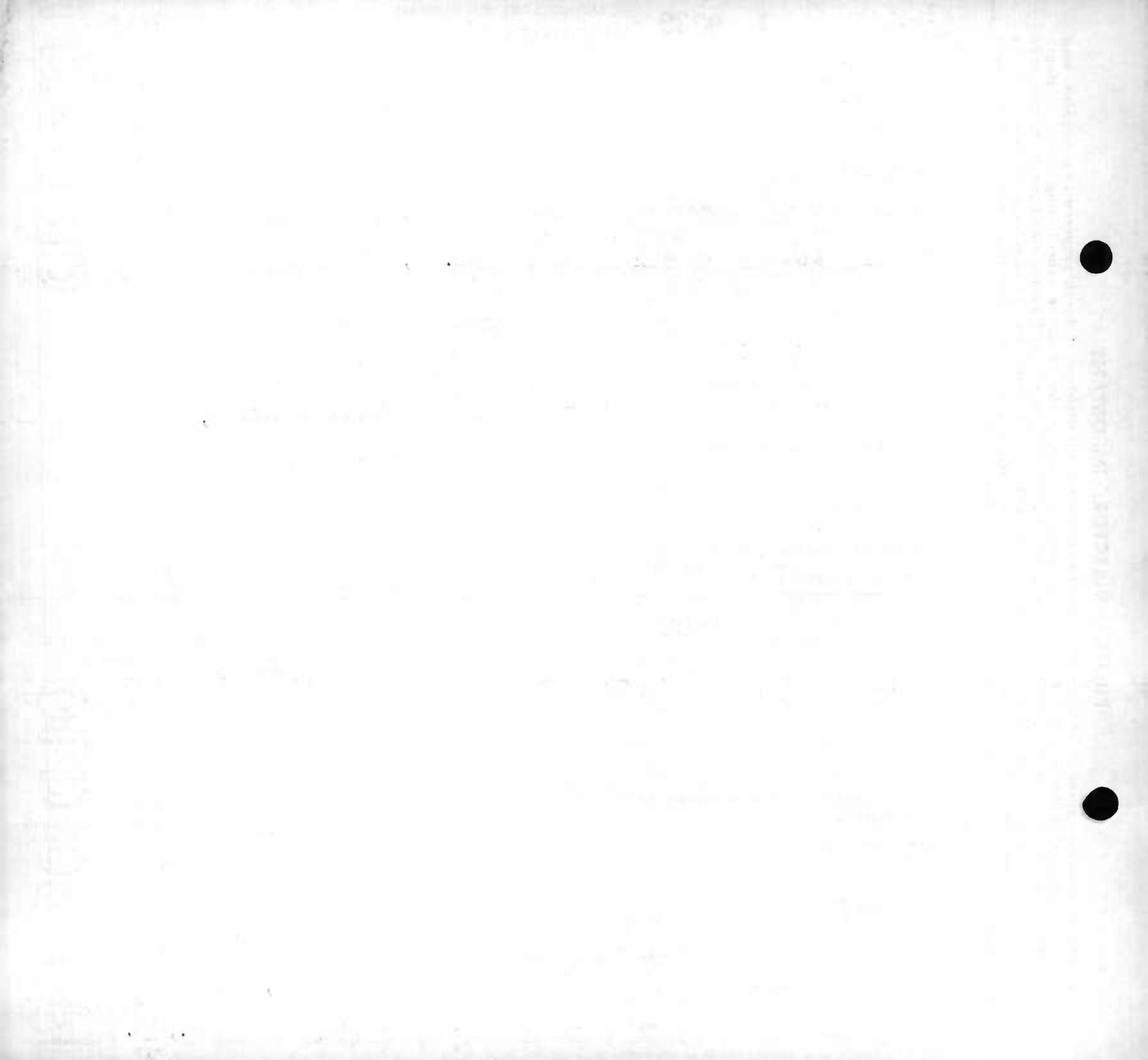
LORING BYERS FUNERAL DIRECTORS, P. A.  
 8728 Liberty Road Randallstown, Md.



# FUNERAL DIRECTOR: IMPORTANT

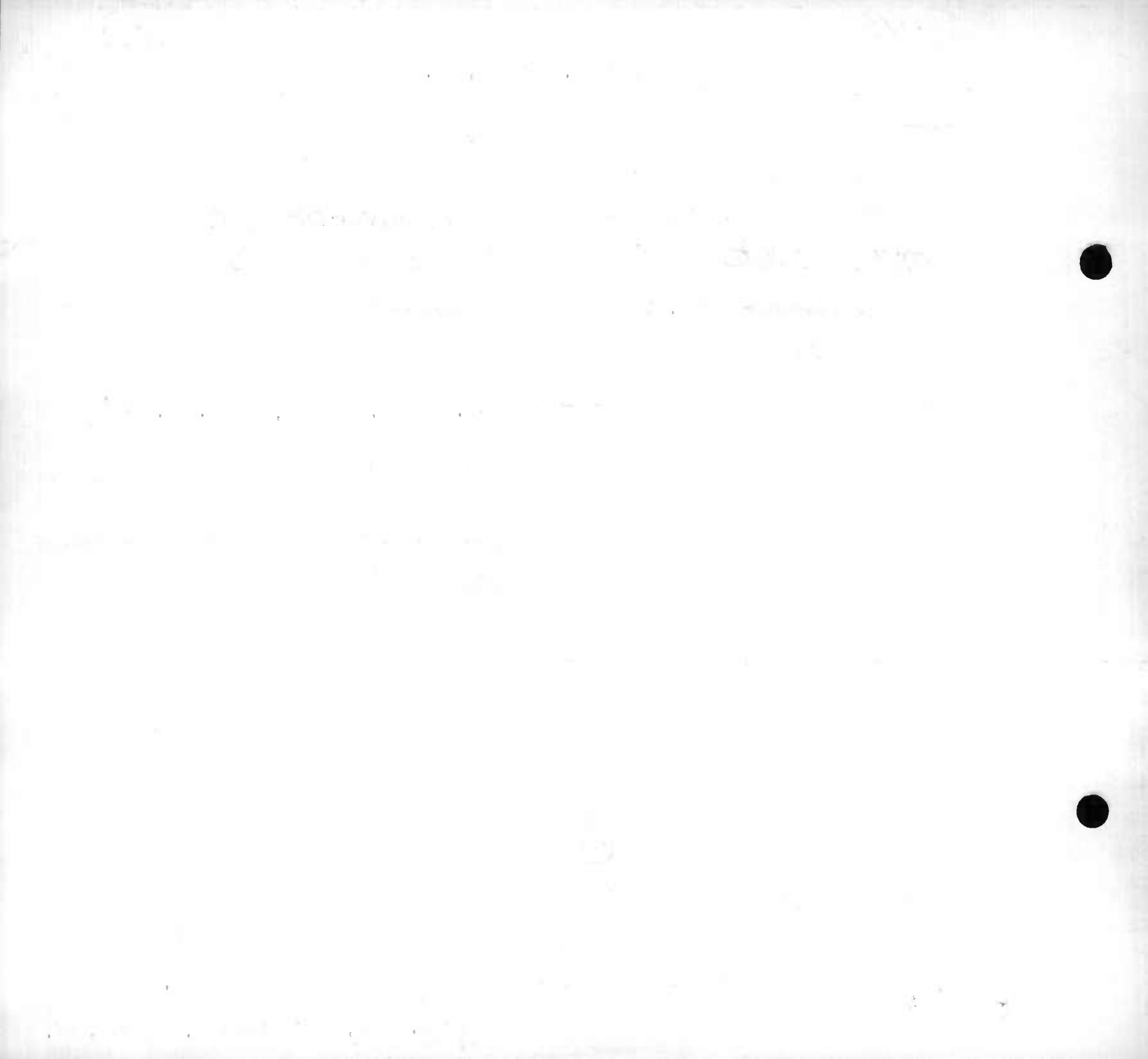
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>G-600</b></span> <span><b>9339</b></span> </div>		<b>CERTIFICATE OF DEATH</b>		<b>REG. NO. 71 9339</b>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Gray, Gladys		10-7-71 7 <sup>45</sup> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE & COUNTY			
South Baltimore 2001 S. Hanover St. General Hospital Baltimore, Md 21230		Md Baltimore 5300			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F		W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Seamstress		Clothing Manufacture Maryland		Dec. 20, 1898	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
John Phillip Pilkerton		Dorcase Cochran		72	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		215-14-9402		Gilbert Gray	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		12. CITIZEN OF WHAT COUNTRY?			
412.4 I		USA			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		11. BIRTHPLACE (State or foreign country)			
ANTECEDENT CAUSES		Maryland			
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Cardiorespiratory arrest			
(B) DUE TO, OR AS A CONSEQUENCE OF:		Cerebral Hemorrhage			
(C) ASCVD					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D N.A.					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
N.A.					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
N.A.		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10-7-71 19 to 10-7-71 19 that (I) (we) last saw the deceased alive on 10-7-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Nelson R. De Lara, M.D.				10-7-71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
NELSON R. DE LARA					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		10-9-71		Holy Cross Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 8 1971		Robert F. Taylor, Jr.		McCutty Funeral Home	
				130 East Fort Avenue Balto., Md. 21230	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>71 9340</b>	
S-140 <b>71 9340</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>SHIPLEY, Lewis</b>		2. DATE AND HOUR OF DEATH <b>10/5/71 10<sup>35</sup> A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>MARYLAND GENERAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Maryland General Hospital</b>		C. CITY OR TOWN <b>Edgemere</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>3119 River Drive Road 21219</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/8/85</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker - Philadelphia</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Richard Shiplee</b>		14. MOTHER'S MAIDEN NAME <b>Clara ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>157-03-5524</b>	
17. INFORMANT (Wife) <b>3119 River Drive Rd.</b> <b>Mrs. Anna E. Shiplee, Balto. Md. 21219</b>		ADDRESS	
18. <b>485X1</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>MULTIPLE STROKES, M.I.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/11</b> 19 <b>71</b> to <b>10/5</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>10/5</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did not) view the body after death.			
23A. SIGNATURE <b>George P. Samaras</b>		23B. DATE SIGNED <b>10/5/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>George P. Samaras M.D.</b>		23D. ADDRESS <b>Maryland General Hospital M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/7/71</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 8 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>John J. Duda</b>		ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-625 71 9341		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 9341	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Julia F. Perkins		Oct. 5-1971 8:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
90 Edgewood Nursing Home 6000 Bellona Ave.			Maryland		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			1713 Park Ave.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	Cauc.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	June 17, 1907	64	Registered Nurse
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Registered Nurse			Maryland		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Thomas W. Bussard			Dulaney		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			216-01-1196		Joseph E. Perkins 108 W. University Pkwy.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Metastasis-CANCER-		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) CANCER of BREAST		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			6 mos -		
			1 yr -		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6/11/71 to 10/5/71 that (I) (we) last saw the deceased alive on 10/5/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Anthony F. Carozza				10/6/1971	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Anthony F. CAROZZA M.D.				5217 York Rd. BA to Md 21212	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		10-9-71		Lorraine Park Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 8 1971		Robert E. Taylor, R.P.		Wm. Cook-Brooks Towson, Inc. Towson, Md.	

10/2/21

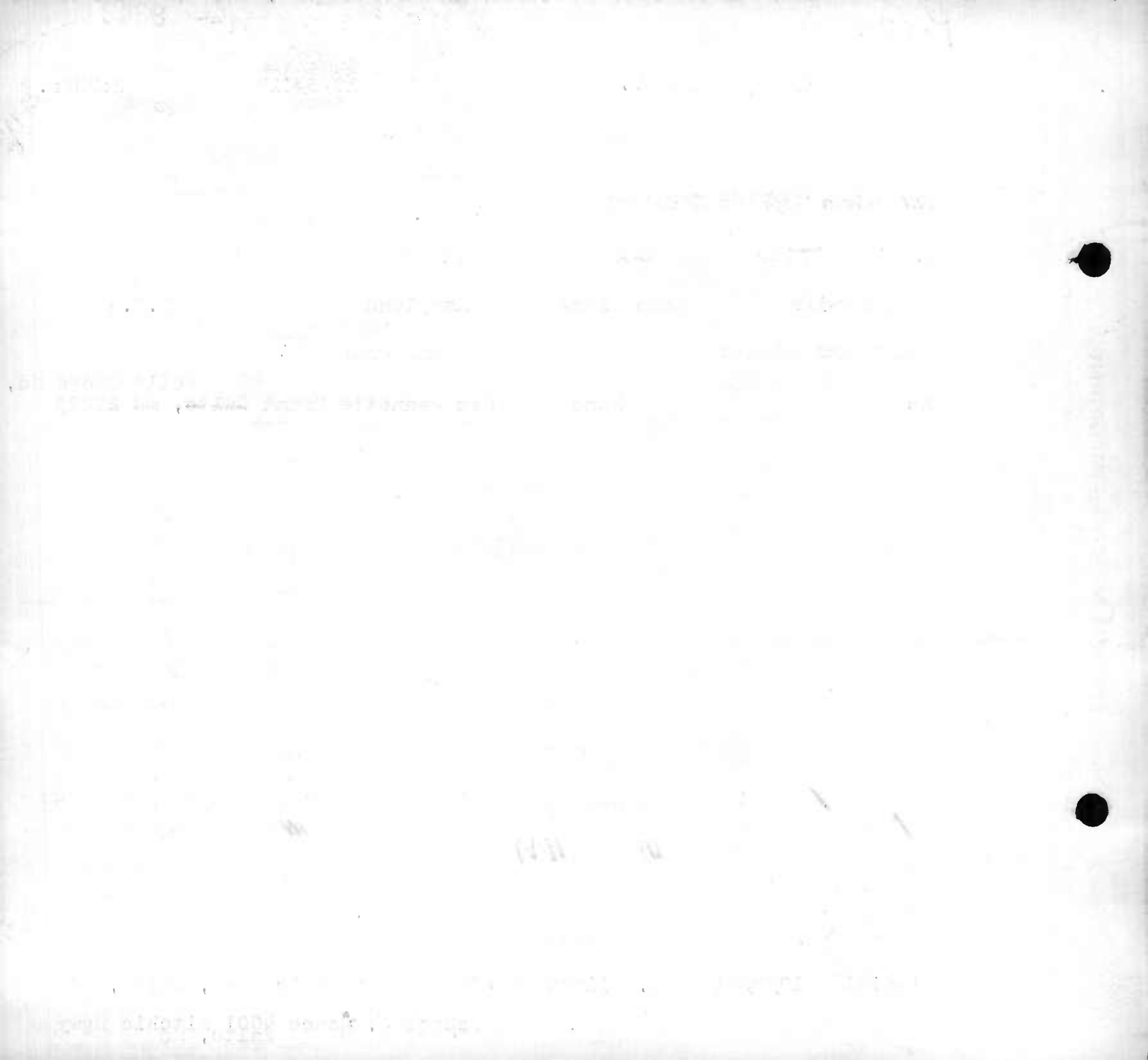
W. J. ...  
...



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

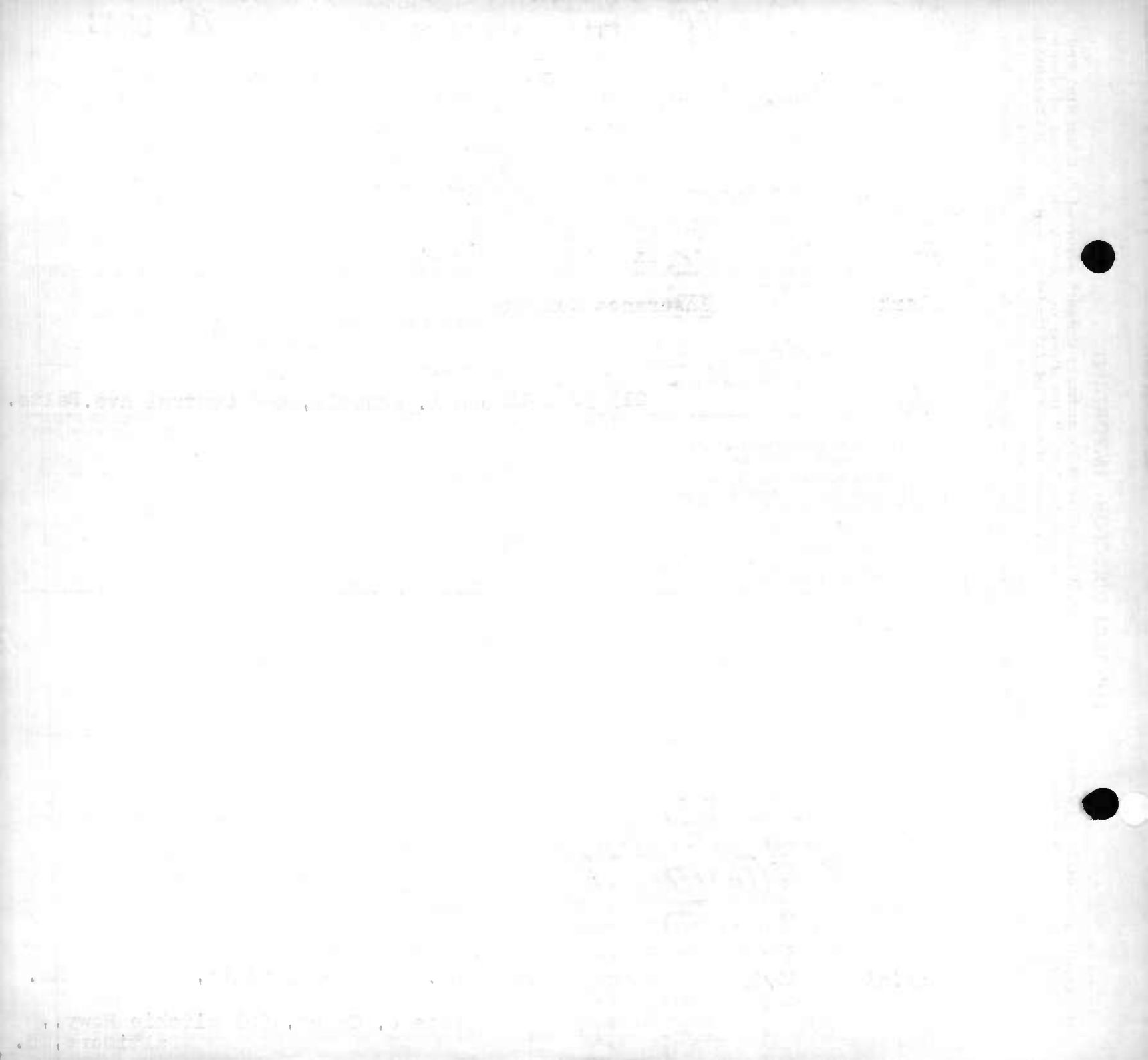
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">71 9342</span>	
BIRTH NO. <span style="float: right;">P-620 71 9342</span>					
1. NAME OF DECEASED (Type or Print) <span style="float: right;">PARKS, Helen V.</span>		2. DATE AND HOUR OF DEATH <span style="float: right;">10/5/71 2:08 a.m.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="float: right;">33 The Johns Hopkins Hospital</span>		A. STATE <span style="float: right;">Maryland</span> B. COUNTY <span style="float: right;">103</span>			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <span style="float: right;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <span style="float: right;">529 S. Port Street</span>			
5. SEX <span style="float: right;">Female</span>	6. RACE <span style="float: right;">White</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="float: right;">6/3/09</span>	9. AGE (in years last birthday) <span style="float: right;">62</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="float: right;">Home Maker</span>		11. BIRTHPLACE (State or foreign country) <span style="float: right;">Maryland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">U.S.A</span>					
13. FATHER'S NAME <span style="float: right;">Ellsworth Miller</span>		14. MOTHER'S MAIDEN NAME <span style="float: right;">Josephine ?</span>			
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <span style="float: right;">No</span>		16. SOCIAL SECURITY NO. <span style="float: right;">None</span>		17. INFORMANT <span style="float: right;">4205 Belle Grove Rd, Mrs Jeanette Grant Balto, Md 21225</span>	
18. <span style="float: right;">440.1 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="float: right;">CAUSE OF DEATH Cardio resusitry arrest</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="float: right;">ASVD</span>			
(B) <span style="float: right;">ASVD</span> DUE TO, OR AS A CONSEQUENCE OF:		(C) <span style="float: right;">ASVD</span> DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="float: right;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <span style="float: right;">Oct 8 1971</span> to <span style="float: right;">Oct 5 1971</span> that (we) last saw the deceased alive on <span style="float: right;">Oct 5 1971</span> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="float: right;">R A Rizzo</span>		23B. DATE SIGNED <span style="float: right;">10/5/71</span>		23C. PHYSICIAN'S NAME (Type) <span style="float: right;">R A Rizzo</span>	
23D. ADDRESS <span style="float: right;">140 Johns Hopkins Hospital</span>		24. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>			
24B. DATE <span style="float: right;">10/8/71</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="float: right;">Mt. Olivet Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="float: right;">Frederick Ave, Balto, Md</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">OCT 8 1971</span>		25B. NAME OF REGISTRAR <span style="float: right;">George J. Gonce</span>		25C. FUNERAL DIRECTOR <span style="float: right;">4001 Ritchie Hwy Balto, Md</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

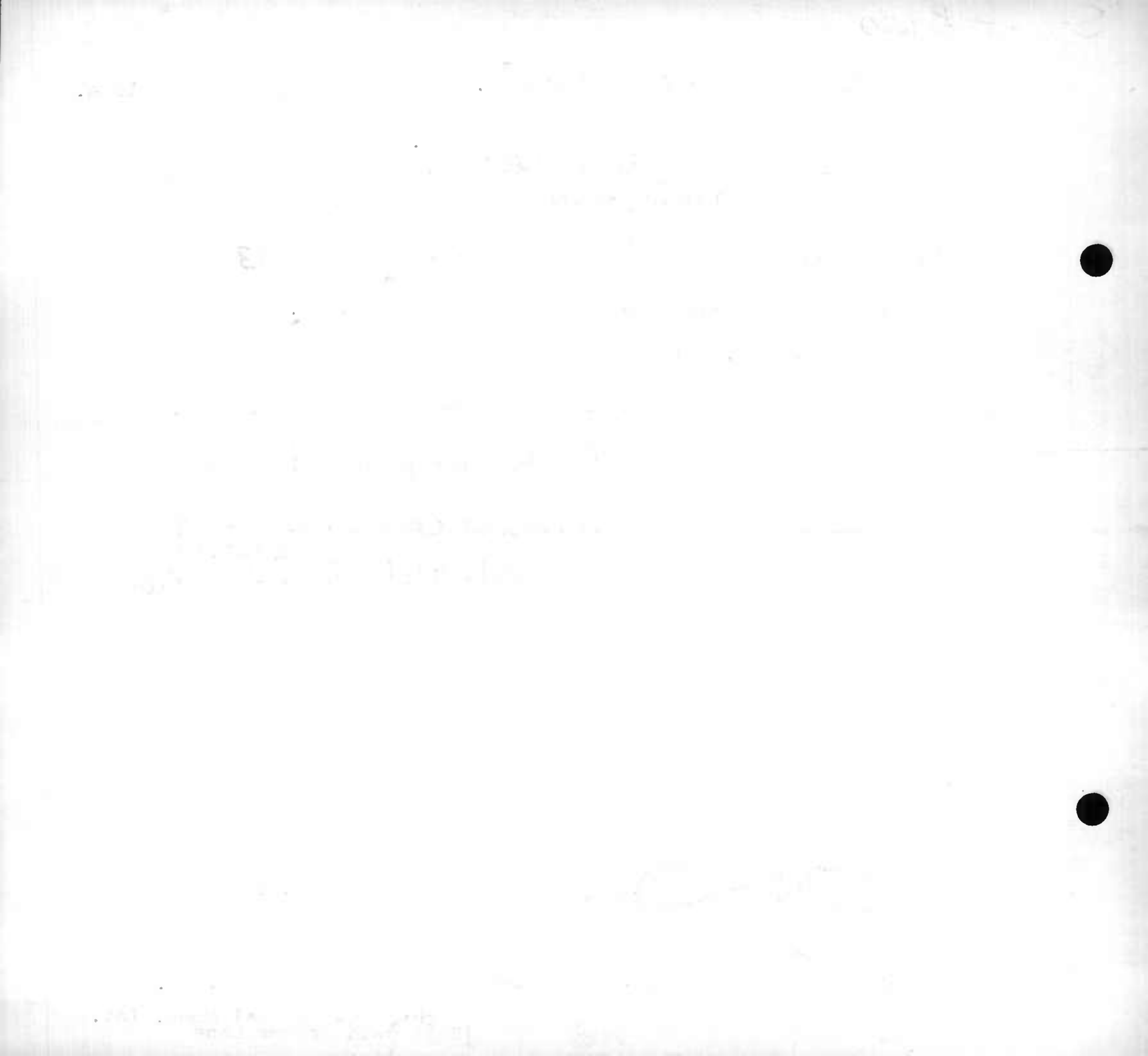
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">71 9343</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">M-220 71 9343</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">MCHUGH, Phoebe E.</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">10-5-71 00-35 A.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">44 UNION MEMORIAL Hospital</span>			A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">2758</span>		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">1745 NORTHERN PKWY</span>		
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">02-22-16</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">55</span>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Clerk</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Insurance Company</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">PENNSYLVANIA</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">LEO GHEE McMULLEN</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">MRS. ELIZABETH NELSON (D)</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213 30 8418</span>		17. INFORMANT <span style="font-size: 1.2em;">Joan A. Russell, 6040 Central Ave. Balto.</span>	
18. <span style="font-size: 1.2em;">250.9 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">A.S.C.U.D. Disease</span> (B) <span style="font-size: 1.2em;">Diabetes Mellitus</span> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">5 years</span>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">D</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">9-4</span> 19 <span style="font-size: 1.2em;">71</span> to <span style="font-size: 1.2em;">10-5</span> 19 <span style="font-size: 1.2em;">71</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">10-5</span> 19 <span style="font-size: 1.2em;">71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">[Signature] MD</span>			23B. DATE SIGNED <span style="font-size: 1.2em;">10-5-1971</span>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">CARLOS ALBERTO BATTILANE MD</span>			23D. ADDRESS <span style="font-size: 1.2em;">UNION MEMORIAL Hospital</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">10/7/71</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Dulaney Valley Mem.</span>	
				24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Cockeysville, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">OCT 8 1971</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. [Signature]</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">George J. Gonce, 4001 Ritchie Hwy., Baltimore, Md.</span>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

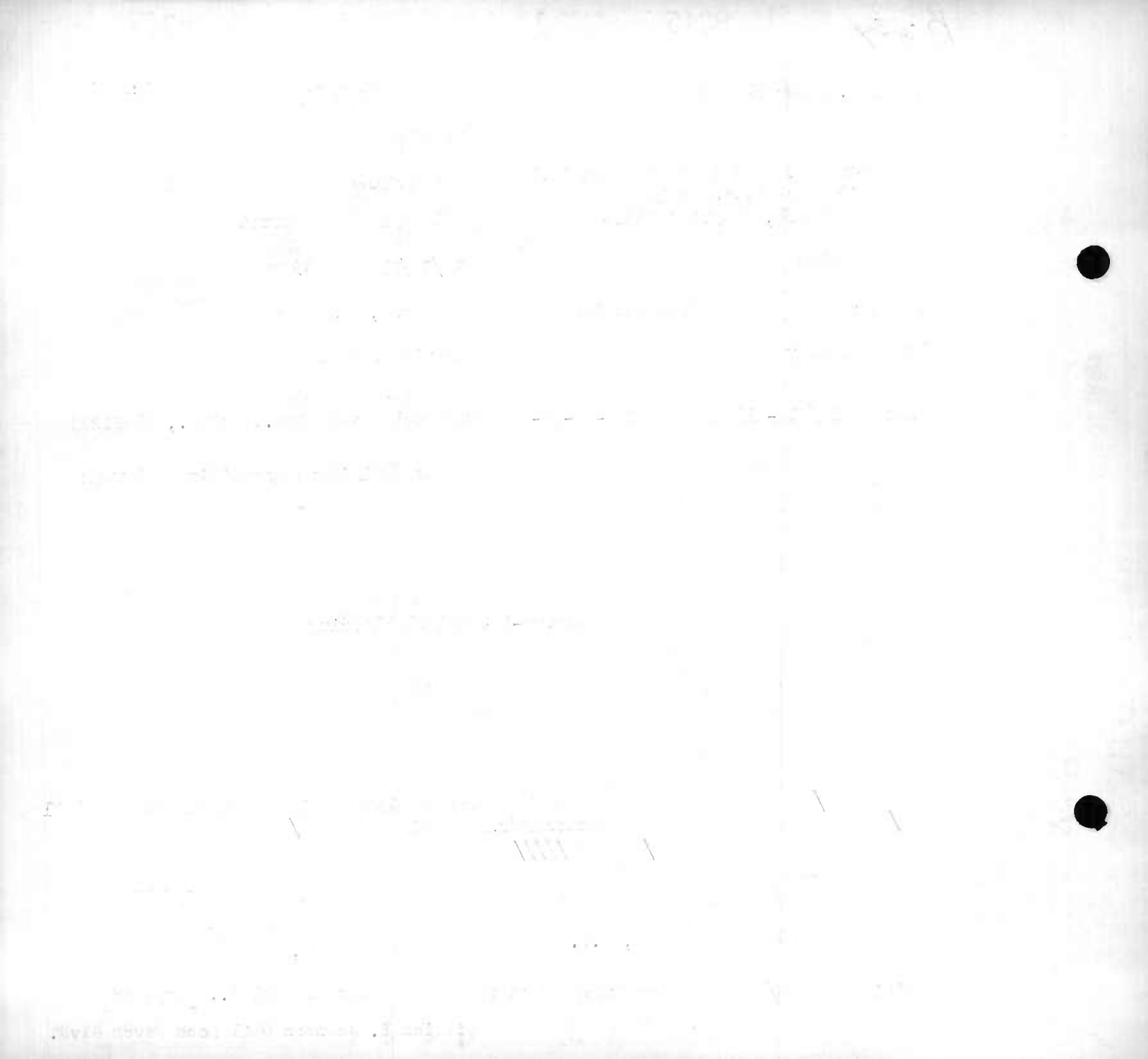
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9344</u>	
BIRTH NO. <u>71 9344</u>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>SELBY, GEORGE Parks Sr.</u>		2. DATE AND HOUR OF DEATH <u>10/3/71</u> <u>10 a.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2734</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL of BALTIMORE MARYLAND</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>5507 Hilltop Avenue</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/18/98</u>	9. AGE (In years last birthday) <u>73</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Crown Cook &amp; Seal</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>George O. Selby</u>		14. MOTHER'S MAIDEN NAME <u>Druscilla Parks</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-07-0179</u>		17. INFORMANT <u>Ruth McNeave Selby, wife, above</u>	
18. I <u>162-1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> <u>Cardio-Respiratory failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Terminal Carcinoma of Lung</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>with Metastasis (Right Rib)</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> <u>9109</u> DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/6/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 8 1971</u>		25B. NAME OF REGISTRAR <u>Ruth E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Schmuck Funeral Home, Inc.</u> <u>13331 Bexx Brehms Lane</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 9345	
CERTIFICATE OF DEATH					
BIRTH NO. <u>B-634</u>		1. NAME OF DECEASED (Type or Print) <u>BRADLEY, LEWIS EDWARD</u>			
2. DATE AND HOUR OF DEATH <u>10/4/71</u> <u>1:40 P</u> M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
<u>23 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>		<u>Maryland</u> A. STATE B. COUNTY			
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>10/20/21</u>		9. AGE (in years last birthday) <u>49</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thomas Bradley</u>	
14. MOTHER'S MAIDEN NAME <u>Marie Sanders</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>10/42 - 10/45</u>		16. SOCIAL SECURITY NO. <u>215-14-59-80</u>	
17. INFORMANT <u>VA Hospital Records</u>		18. ADDRESS <u>3900 Loch Raven Blvd., Balto., Md 21218</u>		19. CAUSE OF DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Acute fulminant hepatitis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Gastro-intestinal bleeding</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>October 1st</u> 19 <u>71</u> to <u>October 4th</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>October 4th</u> 19 <u>71</u> and that (I) (we) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stephen Greenberg</u>		23B. DATE SIGNED <u>107/71</u>		23C. PHYSICIAN'S NAME (Type) <u>STEPHEN GREENBERG, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/8/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Glen Haven Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Anna Arundel Co., Maryland</u>		24E. NAME OF REGISTRAR <u>William E. Johnson</u>		24F. FUNERAL DIRECTOR <u>8521 Loch Raven Blvd.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 8 1971</u>		25B. NAME OF REGISTRAR <u>William E. Johnson</u>		25C. FUNERAL DIRECTOR <u>8521 Loch Raven Blvd.</u>	





## CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)71 9346  
Burger, Frank John

2. DATE AND HOUR OF DEATH

10/3/71 18:25 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4940 Eastern Ave. Baltimore, Md. 21224

Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland, Baltimore 2610

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

508 N. Clinton Street

5. SEX

Male

6. RACE

White

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

9/4/99

9. AGE (In years last birthday)

72

If Under 1 Yr.

Months: Days:

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Machinist - Beth. Steel Co.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Tobias

14. MOTHER'S MAIDEN NAME

Amalia VY Beck

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

213-07-2370A

17. INFORMANT

B.C.H. Records: 4940 Eastern Ave. Baltimore, Md. 21224

ADDRESS

18. 162.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiorespiratory Arrest 2° to Metastatic Carcinoma of (R) Lung - 25 days

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

None

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9-8 19 71 to 10-3- 19 71 that (I) (we) last saw the deceased alive on 10-3- 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Roland C. Einhorn, M.D.

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

10/3/71

23C. PHYSICIAN'S NAME (Type)

Roland C. Einhorn M.D.

DEGREE

23D. ADDRESS

Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

10/6/71

Oak Lawn Cemetery

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

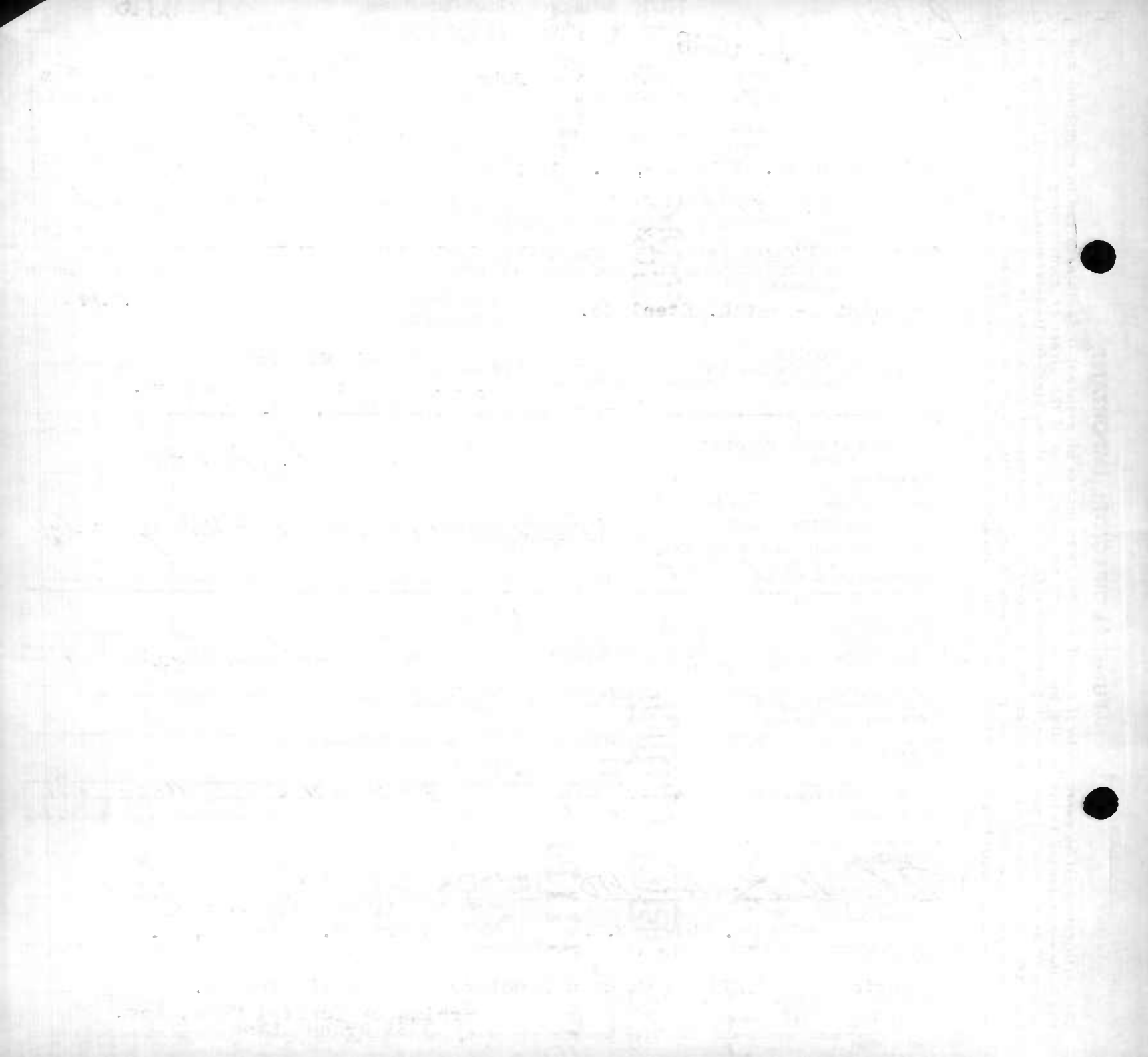
OCT 8 - 1971

Schimunek Funeral Home, Inc.

3331 Brehms Lane

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">71 9347</span>
BIRTH NO. <span style="font-size: 1.5em;">B-635</span>		71 9347		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Margaret Webb Broadnax		10-6-71		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
00 1605 W. Mosher Street		Maryland 1603		
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
Female		Negroid		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH
Nurse's Aid				12-5-20
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)
Jack Webb		Nellie		50
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)
no				N.C.
17. INFORMANT		12. CITIZEN OF WHAT COUNTRY?		
Maydene Webb		U.S.A.		
18. 404X I		1627 W. Mosher St.		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Respiratory Failure		
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Hypertension, Coronary artery disease		
		(B) DUE TO, OR AS A CONSEQUENCE OF		
		Myocardial infarction		
		(C)		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from <u>June 71</u> to <u>October 6 1971</u> that (I) (we) last saw the deceased alive on <u>Oct 18 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
<u>J. Shorofsky M.D.</u>				<u>10/7/71</u>
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
<u>S. Boroffsky</u>		<u>601 N. Monrovia Rd. #217</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY
Burial		10-8-71		Mt. Auburn Cem.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
OCT 8 1971		<u>Robert E. Taylor, M.D.</u>		<u>V. Bailey</u>
				ADDRESS
				<u>1348 Calhoun Street</u>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

B-650 71 9348		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9348	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		JAMES HENRY BROWN		2. DATE AND HOUR OF DEATH 10-7-71 12:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD B. COUNTY 1501		5. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSP OF MD		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. SEX M		7. RACE N		8. DATE OF BIRTH 8-1-06	
9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		10. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. AGE (In years last birthday) 65 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
13. FATHER'S NAME JAMES T. BROWN		14. MOTHER'S MAIDEN NAME May E.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 213-14-5582		17. INFORMANT MARY BROWN 1702 CAREY ST.	
18. 250.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: DIABETIC KETO-ACIDOSIS		8-10 hrs	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		SEVERE ANAEMIA			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-6-71 to 10-7-71		that (I) (we) lost saw the deceased alive on 10-7-71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE AJAZ ARAIN MD		23B. DATE SIGNED 10-7-71			
23C. PHYSICIAN'S NAME (Type) AJAZ ARAIN MD		23D. ADDRESS LUTHERAN HOSP OF MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-11-71		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.	
24D. LOCATION BALTO., Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 8 1971		25B. NAME OF REGISTRAR Robert E. Bailey MD	
25C. FUNERAL DIRECTOR V. BAILEY		25D. ADDRESS 1340 N. CALHOUN ST.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 71

9349

BIRTH NO. 71 9349

1. NAME OF DECEASED  
(Type or Print)

Edith G. Miller

2. DATE AND HOUR OF DEATH

10-7-71 9:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 705 GLEN ALLEN DR.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

MD

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

705 GLEN ALLEN DR.

5. SEX

F

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

8-23-96

9. AGE (in years last birthday)

75

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Walter A. McKelvy

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.  
215-05-3770

17. INFORMANT

Stanley B. Miller, 705 Glen Allen Drive

ADDRESS

18.

410-0 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Coronary artery occlusion

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Hypertension & arteriosclerotic changes

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

osteoarthritis

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-26-1965 to 10-7-1971 that (I) (we) last saw the deceased alive on 10-6-1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Harry L. Knipp, M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

10-7-71

23C. PHYSICIAN'S NAME (Type)

Dr. Harry L. Knipp

23D. ADDRESS

4116 Edmondson Avenue

Baltimore, Md. 21229

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/9/71

24C. NAME of CEMETERY or CREMATORY

Woodlawn Cemetery

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

OCT 8 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Mitche, 11655 Edmondson Ave.

ADDRESS

21 228





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N. 425

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 9350	
BIRTH NO. 71 9350		1. NAME OF DECEASED (Type or Print) NELSON, GERALDINE LOUISE		2. DATE AND HOUR OF DEATH OCTOBER 06, 1971 9:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL CATON & WILKENS AVE.				A. STATE WISCONSIN		B. COUNTY WAUSAU	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 1212 ARTHUR ST-			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/30/10	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WISCONSIN	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME OTTO WEILAND			
14. MOTHER'S MAIDEN NAME ANNA MARQUARDT				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.				17. INFORMANT BALTIMORE, MARYLAND ST AGNES HOSPITAL CATON & WILKENS AVE			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Acute massive coronary thrombosis antebellum 2 days 12 yrs		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from OCTOBER 4 1971 to OCTOBER 6 1971 that (X) (we) last saw the deceased alive on OCTOBER 6 1971 and that (XXX) (our) opinion death occurred on the date and hour and from the causes stated above. (XX) (We) (did) (XXXX) view the body after death.							
23A. SIGNATURE [Signature] M.D.				23B. DATE SIGNED 10/6/71		23C. PHYSICIAN'S NAME (Type) JOSE APTER M.D.	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial				24B. DATE 10/11/71		24C. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Park	
24D. LOCATION (City, town, or county) Wausau, Wisconsin				24E. STATE (State) V		25A. DATE REC'D BY HEALTH DEPT. OCT 8 1971	
25B. NAME OF REGISTRAR Robert E. Taylor M.D.				25C. FUNERAL DIRECTOR Howard County Funeral Home of Harry H. Witzke		25D. ADDRESS 4112 Columbia Pike 21043	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 9351	
S-520 71 9351				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>LOTTIE SUMOWSKI</b>		2. DATE AND HOUR OF DEATH <b>10-7-71 12<sup>15</sup> P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>35 CHURCH HOME &amp; HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>STATE</b> B. COUNTY <b>105</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>321 S. COLLINGTON AVE.</b>			
5. SEX <b>F</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9.12.95</b>	9. AGE (in years last birthday) <b>76</b>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED. NOT KNOWN</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Not known</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Not Available</b>		14. MOTHER'S MAIDEN NAME <b>Not known</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>212 01 5223</b>		17. INFORMANT ADDRESS <b>HOSPITAL CHART</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertension</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>5 yrs</b>	
(C) DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes Mellitus</b>				(D) DUE TO, OR AS A CONSEQUENCE OF: <b>5 yrs</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1967</b> to <b>10-7-71</b> that (I) (we) last saw the deceased alive on <b>10-7-71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Theodore T. Niznik</b>		23B. DATE SIGNED <b>10-7-71</b>		23C. PHYSICIAN'S NAME (Type) <b>Theo. T. NIZNIK MD</b>	
23D. ADDRESS <b>429 S. Chester St 21231</b>		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>10-11-71</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEM</b>		24D. LOCATION (City, town, or county) <b>DUNDALK, BALTO MD</b>		24E. DATE REC'D BY HEALTH DEPT. <b>OCT 8 1971</b>	
24F. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		24G. FUNERAL DIRECTOR <b>THEO. NIZNIK &amp; SONS INC</b>		24H. ADDRESS <b>401 S. CHESTER</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

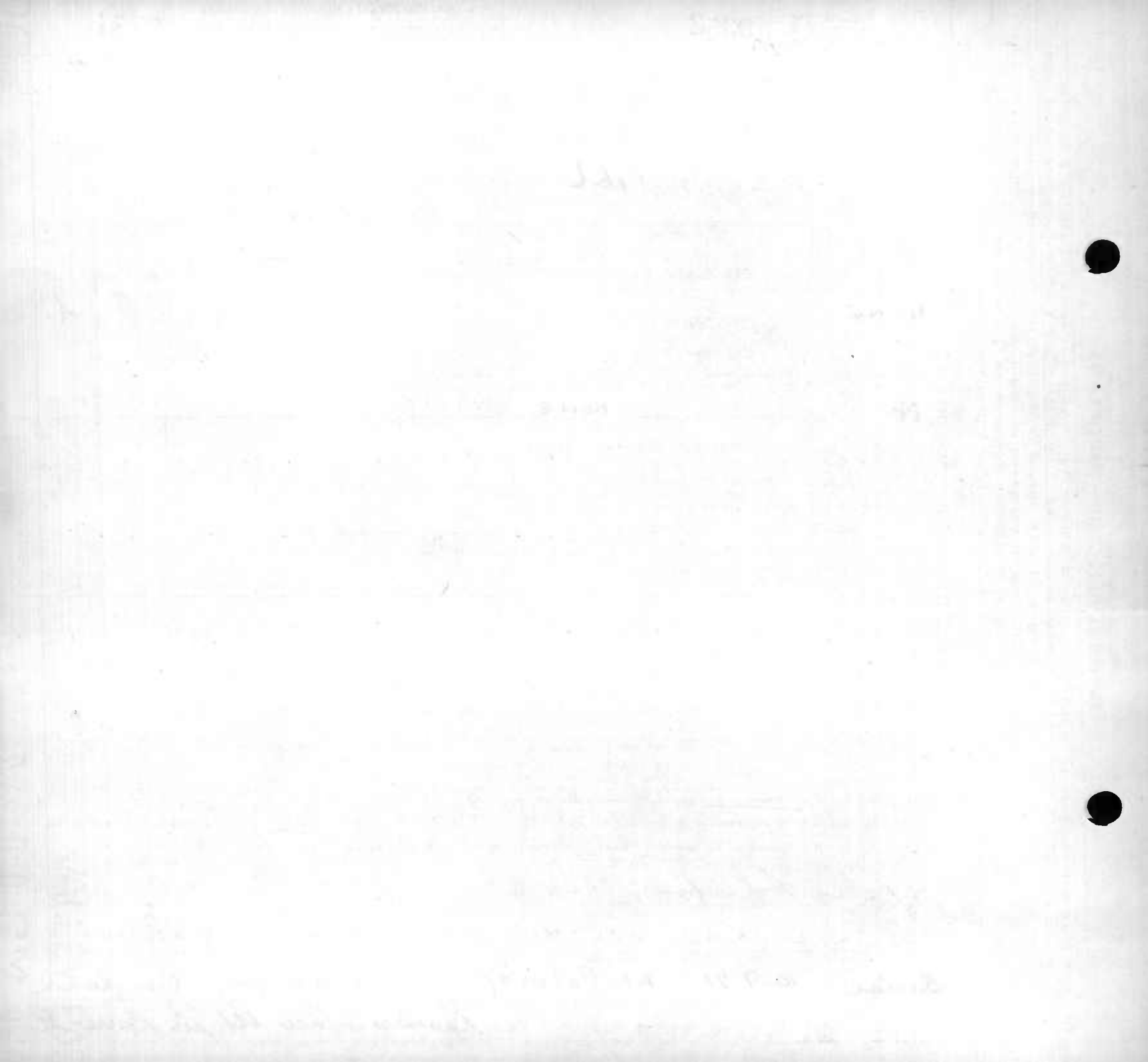
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71-9352</span>	
BIRTH NO. <span style="font-size: 1.5em;">71-9352</span>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
			A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			E. STREET AND NUMBER		YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. CAUSE OF DEATH					
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
				(B) DUE TO, OR AS A CONSEQUENCE OF:	
				(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 9353	
M-625-71 9353				BIRTH NO. 71-14846	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
CHANDRA MORGAN				10-5-71 9 <sup>40</sup> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
UNIV. OF MD. HOSPITAL 38				MD. BALTO. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9. AGE (In years last birthday) 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
F N				9-1-71 1118 CARSON CT.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?	
NONE				BALTO. MD. U.S.A.	
13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
WILLIAM FRAZIER				CONSTANCE MORGAN	
16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS				18. CAUSE OF DEATH	
NONE MOTHER SAME				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	
No				PNEUMONIA 4/OR MYOCARDITIS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				3 DAYS	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) CONGENITAL HEART DIS. (ASD) 1 MONTH	
II				(C) CONGENITAL HEART DIS. (ASD) 1 MONTH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				YES NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21F. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from 9-1-71 to 10-5-71, that (I) (we) last saw the deceased alive on 9-21-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 23B. DATE SIGNED				23C. PHYSICIAN'S NAME (Type) 23D. ADDRESS	
Felix L. Kaufman M.D. 5-OCTOBER-71				FELIX L. KAUFMAN M.D. UNIV. OF MD. HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		10-9-71		Mt. Calvary	
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S 300

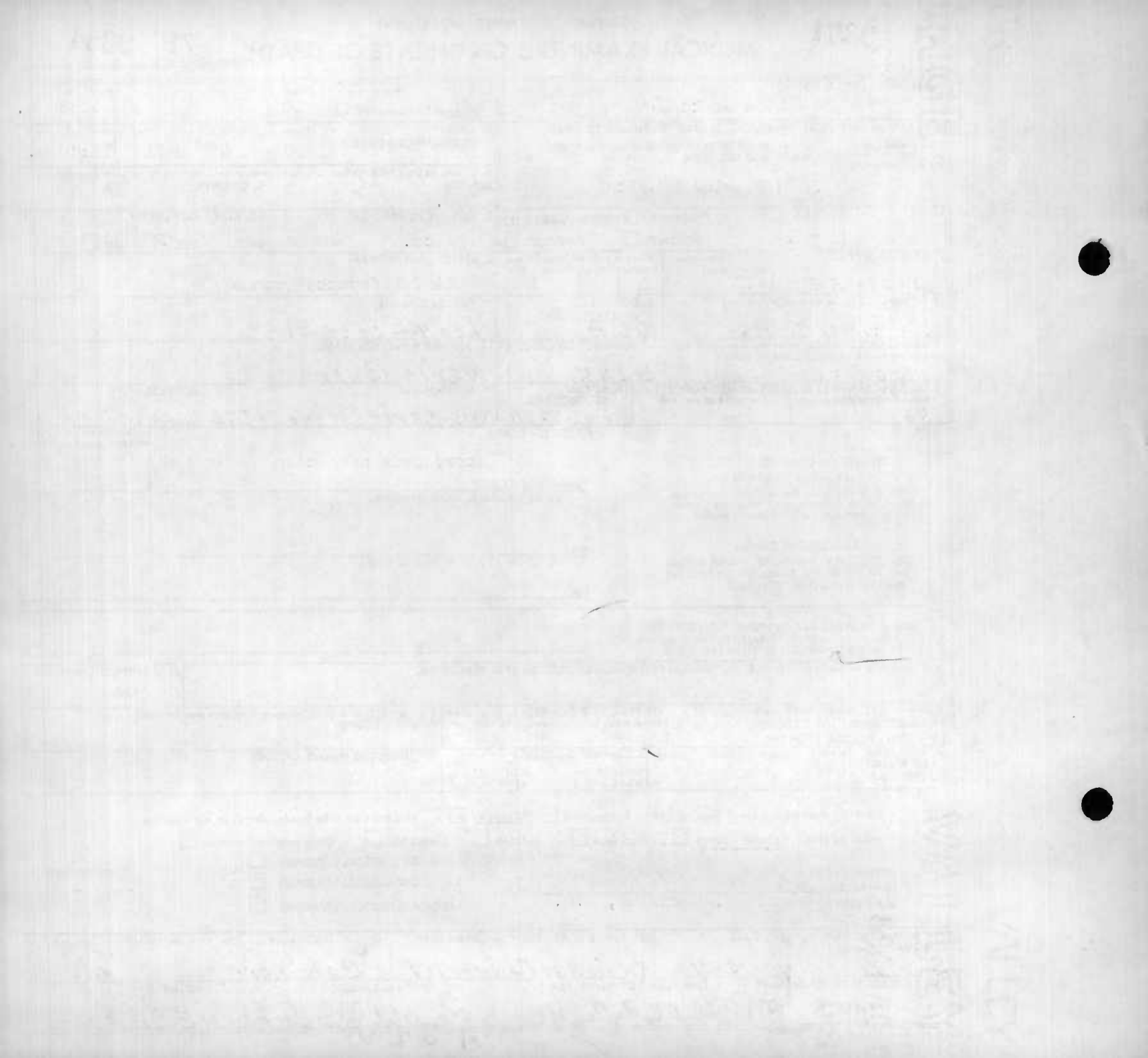
71 9354

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 9354  
REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
		Leon Scott, Jr.		Known <input checked="" type="checkbox"/> Month 10 Day 6 Year 71 Hour 12:20 a.m. Estimated <input type="checkbox"/>		Month 10 Day 6 Year 71 Hour 12:20 a.m.		John Hopkins Hospital		A. STATE Md. B. COUNTY 802	
6. SEX male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH 12-21-53		10. AGE (in years last birthday) 17		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Leon Scott, Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian	
15. MOTHER'S MAIDEN NAME Marie Butts		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215-60-7220		18. INFORMANT Mrs. Marie Scott		19. CAUSE OF DEATH Intravenous narcotism		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		24. DATE OF OPERATION 2		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No) yes	
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		30. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. HOW DID INJURY OCCUR?	
33. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		34. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		35. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		36. DATE SIGNED 10/6/71		37. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial		38. 24B. DATE 10-12-71	
39. 24C. NAME OF CEMETERY or CREMATORY National Cemetery		40. 24D. LOCATION (City, town, or county) Baltimore		41. (State) Md.		42. 25A. DATE REC'D BY HEALTH DEPT. OCT 8 1971		43. 25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		44. 25C. FUNERAL DIRECTOR ADDRESS Randolph J. Collick 2431 E. Oliver St.	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

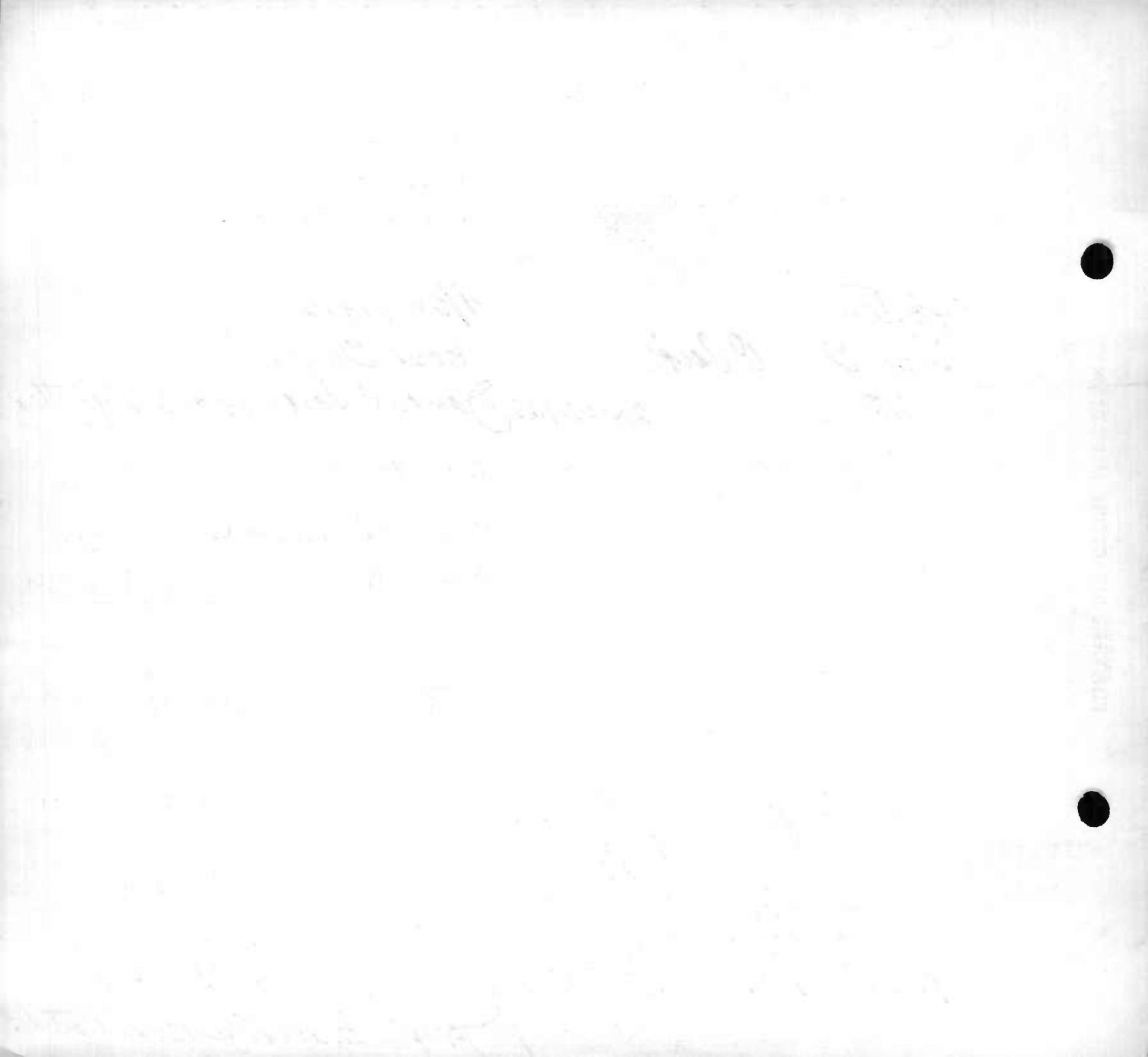
K-520 71 9355		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9355	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MADLINE, KNOX</b>		2. DATE AND HOUR OF DEATH <b>10-6-71 10:14 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>802</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b> <b>600 BROADWAY BALT. MD</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>N</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LAUNDRY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>		8. DATE OF BIRTH <b>4/12/15</b>	
13. FATHER'S NAME <b>FRANCIS BARNES</b>		14. MOTHER'S MAIDEN NAME <b>LUCINDA SHORT</b>		9. AGE (In years last birthday) <b>56</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <b>LONDONTOWN MD.</b>	
17. INFORMANT <b>Mary Waters 1735 Darkey Ave</b>		ADDRESS		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>250.0 I</b>		CAUSE OF DEATH <b>1 Toxic Cellulitis</b> <b>2 Diabetic Coma</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Bact. Cellulitis of both feet</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>due to Diabetic Ulcers.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>11</b>		<b>1 Diabetic Mellitus</b>		<b>2 Long Standing Rheumatoid Arth.</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>HOME.</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>DOA</b> 19 <b>71</b> to <b>OCT. 6</b> 19 <b>71</b> , that (2) (we) last saw the deceased alive on <b>DOA</b> 19 <b>71</b> and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) <b>not</b> view the body after death.		23A. SIGNATURE <b>YOSHIZUMI M.D.</b>		23B. DATE SIGNED <b>10-6-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Marc O. Yoshizumi, M.D.</b>		23D. ADDRESS <b>The Johns Hopkins Hospital</b>		23E. DEGREE <b>DEGREE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/11/71</b>		24C. NAME of CEMETERY or CREMATORY <b>mt Calvary Cem.</b>	
24D. LOCATION <b>A. A. County, Md</b>		24E. CITY, town, or county <b>1304 N. Central Ave</b>		24F. STATE <b>MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 8 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Feltz, Jr.</b>		25C. FUNERAL DIRECTOR <b>Spears &amp; Lock</b>	
25D. ADDRESS <b>1304 N. Central Ave</b>		25E. CITY, town, or county <b>BALTIMORE, MD</b>		25F. STATE <b>MD</b>	

10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

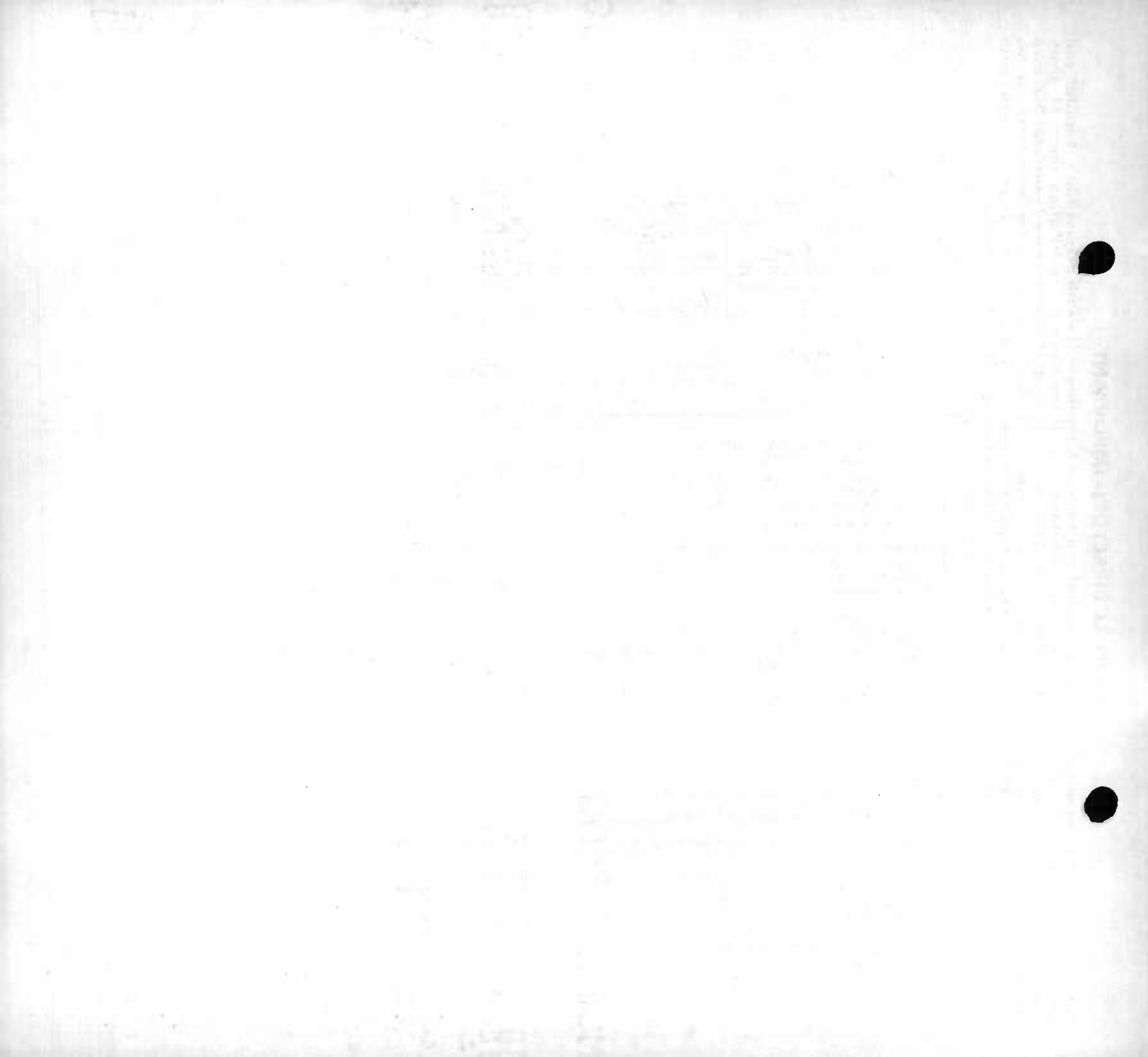
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9356</u>	
C-462 71 9356				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Walter Clark</u>		2. DATE AND HOUR OF DEATH <u>5 October 1971</u> <u>8:40 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>843</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1512 N. Kenwood Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4/26/12</u>	9. AGE (in years last birthday) <u>59</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>porter</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>4/26/1912</u>	
13. FATHER'S NAME <u>Wm. J. Clark</u>		14. MOTHER'S MAIDEN NAME <u>Rose Taylor</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-65-7165</u>		17. INFORMANT <u>James Clark 1901 E. Lafayette</u>	
18. <u>412.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Brain stem Stroke</u> (B) <u>High Blood Pressure</u> (C) <u>ASCVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>15 yrs</u> <u>15-20 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>NO</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>Oct 2</u> 19 <u>71</u> to <u>Oct 5</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>Oct 5</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>George J. Taylor MD</u>				23B. DATE SIGNED <u>10/5/71</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <u>Johns Hopkins Hosp. Baltimore Md</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/9/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>	
24D. LOCATION <u>G. A. County, Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 8 1971</u>			
25B. NAME OF REGISTRAR <u>John E. Taylor MD</u>		25C. FUNERAL DIRECTOR <u>Joseph B. Lock</u>		25D. ADDRESS <u>15047 Connel</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>T-613</u> <u>71</u> <u>9357</u>				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>71</u> <u>9357</u>	
1. NAME OF DECEASED (Type or Print) <u>TAR button, Charles Leroy</u>				2. DATE AND HOUR OF DEATH <u>10-7-71</u> <u>9 34</u> A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2544</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>3905 Eighth St.</u>									
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-3-15</u>	9. AGE (In years last birthday) <u>55</u>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRONICS TECH.</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Westinghouse</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A.</u>	
13. FATHER'S NAME <u>William Tarbutton</u>				14. MOTHER'S MAIDEN NAME <u>DES MERELDA GLOVER</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>217-07-1632</u>		17. INFORMANT ADDRESS <u>MRS. LOUISE E. TARBUTTON (SAME)</u>					
18. <u>7-12-3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Septicemia</u> <u>2 1/2 days</u>					
				(B) <u>Rheumatoid Arthritis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>20+ yrs.</u>					
				(C) <u>Steroid Therapy</u> <u>15+ yrs.</u>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>									
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <u>5-Oct</u> 19 <u>71</u> to <u>7-Oct</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>7-Oct</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Richard E. Fisher MD</u>				23B. DATE SIGNED <u>7-Oct-71</u>		23C. PHYSICIAN'S NAME (Type) <u>Richard E. Fisher MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>10-11-1971</u>		24C. NAME of CEMETERY or CREMATORY <u>Greenmount</u>		24D. LOCATION (City, town, or county) <u>Balto., Md.</u>		24E. (State) <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 8 - 1971</u>		25B. NAME OF REGISTRAR <u>Reg. of Health</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co.</u>		25D. ADDRESS <u>4905 York Road Balto., Md. 21212</u>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 71 9358	
<div style="display: flex; justify-content: space-between;"> <span>S-540 71 9358</span> <span>BIRTH NO.</span> </div>							
1. NAME OF DECEASED (Type or Print) <b>SCHAMEL, Norman Wesley</b>				2. DATE AND HOUR OF DEATH <b>10/4/71</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>AA</b> C. CITY OR TOWN <b>Pasadena</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Magathy Bridge Rd RT #14 Box 27A</b>			
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/11/11</b>	
9. AGE (In years last birthday) <b>60</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles H. Schamel</b>				14. MOTHER'S MAIDEN NAME <b>Gertrude May Brown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 2/15/44 - 12/7/45</b>		16. SOCIAL SECURITY NO. <b>705-14-0951</b>		17. INFORMANT <b>VA Hospital Records</b> ADDRESS <b>3900 Loch Raven Boulevard Balto Md</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>710.9 I</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Bilateral bronchopneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>40 minutes</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>September 11 1971</b> to <b>October 4 1971</b> that (1) (we) last saw the deceased alive on <b>October 4 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>11 (We) (did) (did not) view the body after death.</b>							
23A. SIGNATURE <b>Noel S Gressieux</b>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>NOEL S GRESSIEUX, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct. 7, 1971</b>		24C. NAME of CEMETERY or CREMATORY <b>Glen Haven Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie AA Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 8 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>LARRY NELSON</b>		ADDRESS <b>Ritchie Hwy. Severna Park, Md.</b>	

Hydrolyse der wässrigen Lösung

Hydrolyse 1. Versuch

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">71 9359</span>	
<b>1. NAME OF DECEASED</b> (Type or Print)  <div style="text-align: center; font-weight: bold;">LOUIS FEIT</div>		<b>2. DATE AND HOUR OF DEATH</b>  <div style="text-align: center;">October 4, 1971 <span style="float: right;">7:45 a.m.</span></div>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <div style="text-align: center;">Jewish Convalescent &amp; Nursing Home 4601 Pall Mall Road</div>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <input checked="" type="checkbox"/> MARYLAND B. <del>XXXXX</del> <b>5. CITY OR TOWN</b> RANDALLSTOWN <b>6. STREET AND NUMBER</b> 3726 FIELDSTONE ROAD <b>7. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>5. SEX</b> Male	<b>6. RACE</b> White	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> 06/03/1903	<b>9. AGE</b> (In years last birthday) 78 68	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) PAINTER
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) PAINTER		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> PAINTING		<b>11. BIRTHPLACE</b> (State or foreign country) POLAND	<b>12. CITIZEN OF WHAT COUNTRY?</b> United States
<b>13. FATHER'S NAME</b> ISAAC AARON FEIT			<b>14. MOTHER'S MAIDEN NAME</b> MALI GOLDMAN		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) NO		<b>16. SOCIAL SECURITY NO.</b> 220-07-9164		<b>17. INFORMANT</b> MRS. ANNE SIEGEL, 3726 FIELDSTONE RD. #21133	
<b>18. CAUSE OF DEATH</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> 3 days years years
<b>19A. DATE OF OPERATION</b> 1971		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> No		<b>20A. AUTOPSY?</b> (Yes or No) No	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Approx.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that</b> (1) (this hospital) attended the deceased from January 19 70 to Oct. 4 19 71, that (1) (we) last saw the deceased alive on Octob. 1st 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
<b>23A. SIGNATURE</b> <div style="text-align: center;">/ Ardaiz</div>				<b>23B. DATE SIGNED</b> 10-4-71	
<b>23C. PHYSICIAN'S NAME</b> (Type) JOSE ARDAIZ M.D.				<b>23D. ADDRESS</b> SINAI HOSPITAL OF BALTIMORE	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) BURIAL		<b>24B. DATE</b> 10-6-71		<b>24C. NAME OF CEMETERY or CREMATORY</b> TIFERETH ISRAEL ANSHE SFARD	
<b>24D. LOCATION</b> (City, town, or county) (State) ROSEDALE, MARYLAND					
<b>25A. DATE REC'D BY HEALTH DEPT.</b> OCT 8 1971		<b>25B. NAME OF REGISTRAR</b> Robert Epstein, M.D.		<b>25C. FUNERAL DIRECTOR</b> SQU LEVINSON	
<b>25D. ADDRESS</b> BROS., 6010 REISTERSTOWN ROAD					

RECEIVED

NOV 19 1964

U.S. DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20535

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 11/19/64

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

NOV 19 1964

U.S. DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20535

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 11/19/64

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

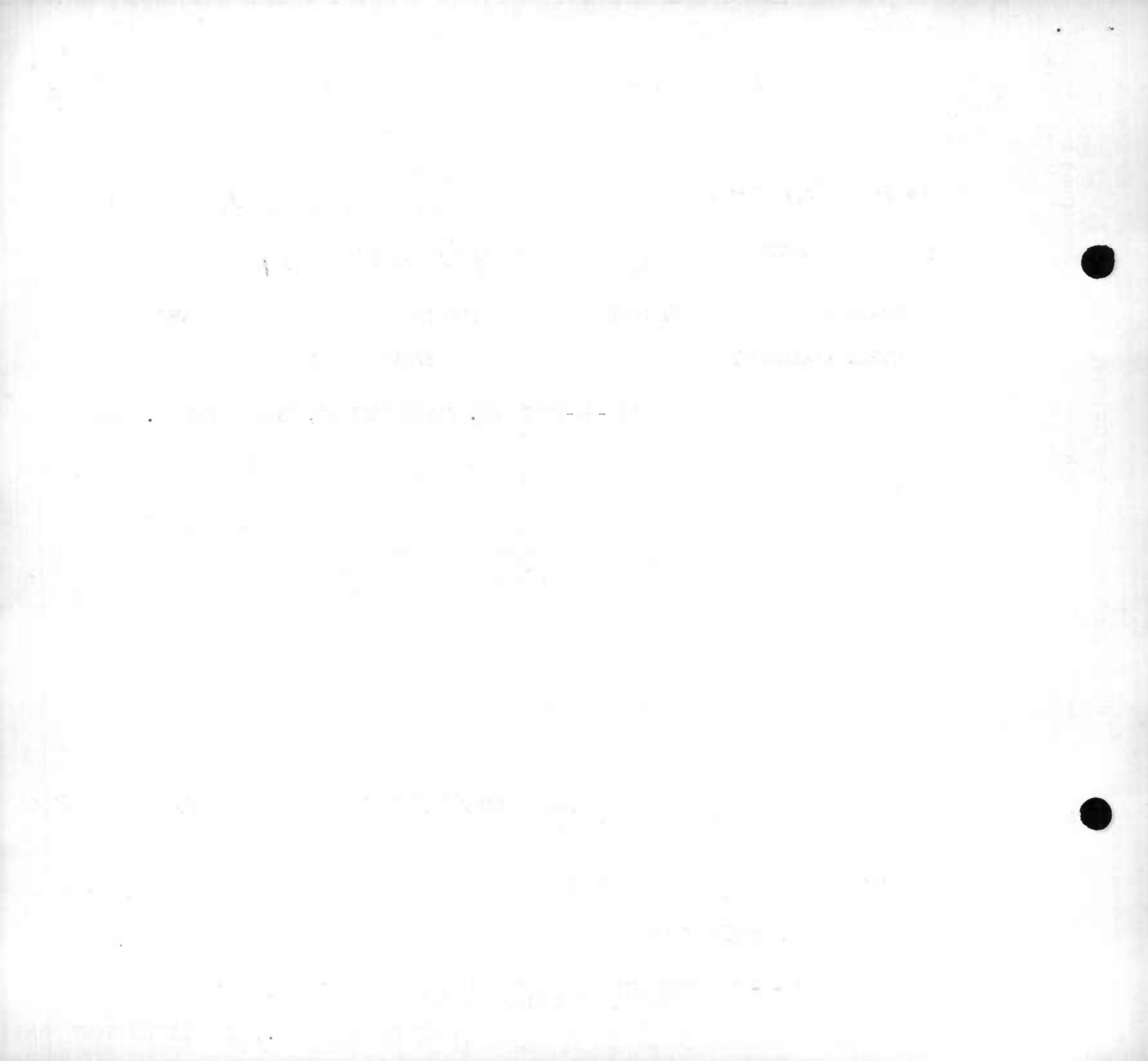
16. [Illegible]

17. [Illegible]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

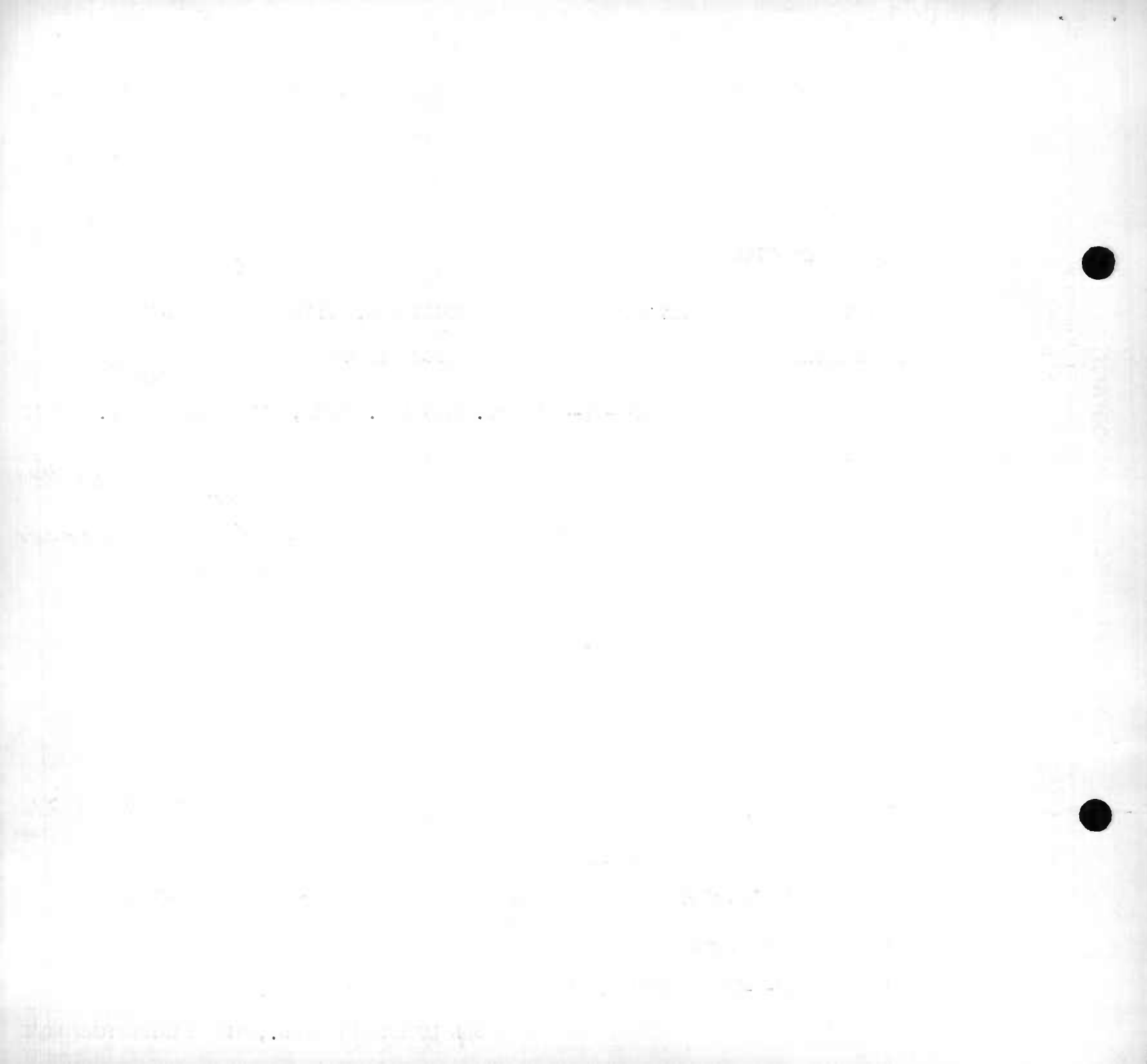
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9360</span>	
L-132 71 9360				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">LAPIDUS, EVA</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">10/4/71</span> <span style="float: right;">1 00 P.M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">SINAI HOSPITAL</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">5300</span> C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">8106 ANITA RD. #3</span>			
5. SEX <span style="font-size: 1.2em;">FEMALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">4/2/1897</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">74</span>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">HOUSEWIFE</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">AT HOME</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">RUSSIA</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">SAMUEL GREENBERG</span>			
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">SADIE ?</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">218-40-8097</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">MR. ALVIN LAPIDUS, 8106 ANITA RD. #21208</span>			
18. <span style="font-size: 1.2em;">410.9 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">CARDIOGENIC SHOCK</span> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">CORONARY ART. DISEAS.</span> <span style="font-size: 1.2em;">Acute M.I.</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">4-5 hrs.</span>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">10/2/71</span> 19 <span style="font-size: 1.2em;">10/4</span> 19 <span style="font-size: 1.2em;">71</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">10/4</span> 19 <span style="font-size: 1.2em;">71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">M.D. [Signature]</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">10/4/71</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">R. MICHAELIDES</span>		23D. ADDRESS <span style="font-size: 1.2em;">SINAI HOSPITAL</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">10-6-71</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">BETH EYEHUDA ANSHE KURLAND</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">OCT 8 1971</span>			
25B. FUNERAL DIRECTOR <span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS.</span>		25C. ADDRESS <span style="font-size: 1.2em;">6010 REISTERSTOWN ROAD</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 9361</b>	
CERTIFICATE OF DEATH					
BIRTH NO. <b>K-450 71 9361</b>					
1. NAME OF DECEASED (Type or Print) <b>Philip L. Klein</b>			2. DATE AND HOUR OF DEATH <b>10-3-71 11:00 A. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL OF BALTO INC.</b> <b>42</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2831</b>		
			C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>4115 Newbern Ave 21215</b>		
5. SEX <b>Male</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-05-05</b>	9. AGE (In years last birthday) <b>65</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>CHARLES KLEIN</b>			14. MOTHER'S MAIDEN NAME <b>ANNA ECHIKSON</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-07-6945</b>		17. INFORMANT <b>MR. JULIUS E. KLEIN, 4115 NEWBERN AVE. #21215</b>	
18. <b>412.4 IV-200.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASC. U.S. DIABETES MELLITUS</b> DUE TO, OR AS A CONSEQUENCE OF: <b>LYMPHOSARCOMA</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 MONTHS</b> <b>14 YEARS</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>10-3-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-25 1971</b> to <b>10-3 1971</b> that (I) (we) last saw the deceased alive on <b>10-3 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Philip L. Klein</b>				23B. DATE SIGNED <b>10-3-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>TELL BUTIERRE</b>		23D. ADDRESS <b>SINAI HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-6-71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MIKRO KODESH</b>	
24D. LOCATION <b>BALTIMORE, MARYLAND</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 8 1971</b>		25B. NAME OF REGISTRAR <b>SOLOMON</b>		25C. FUNERAL DIRECTOR <b>SOLOMON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	

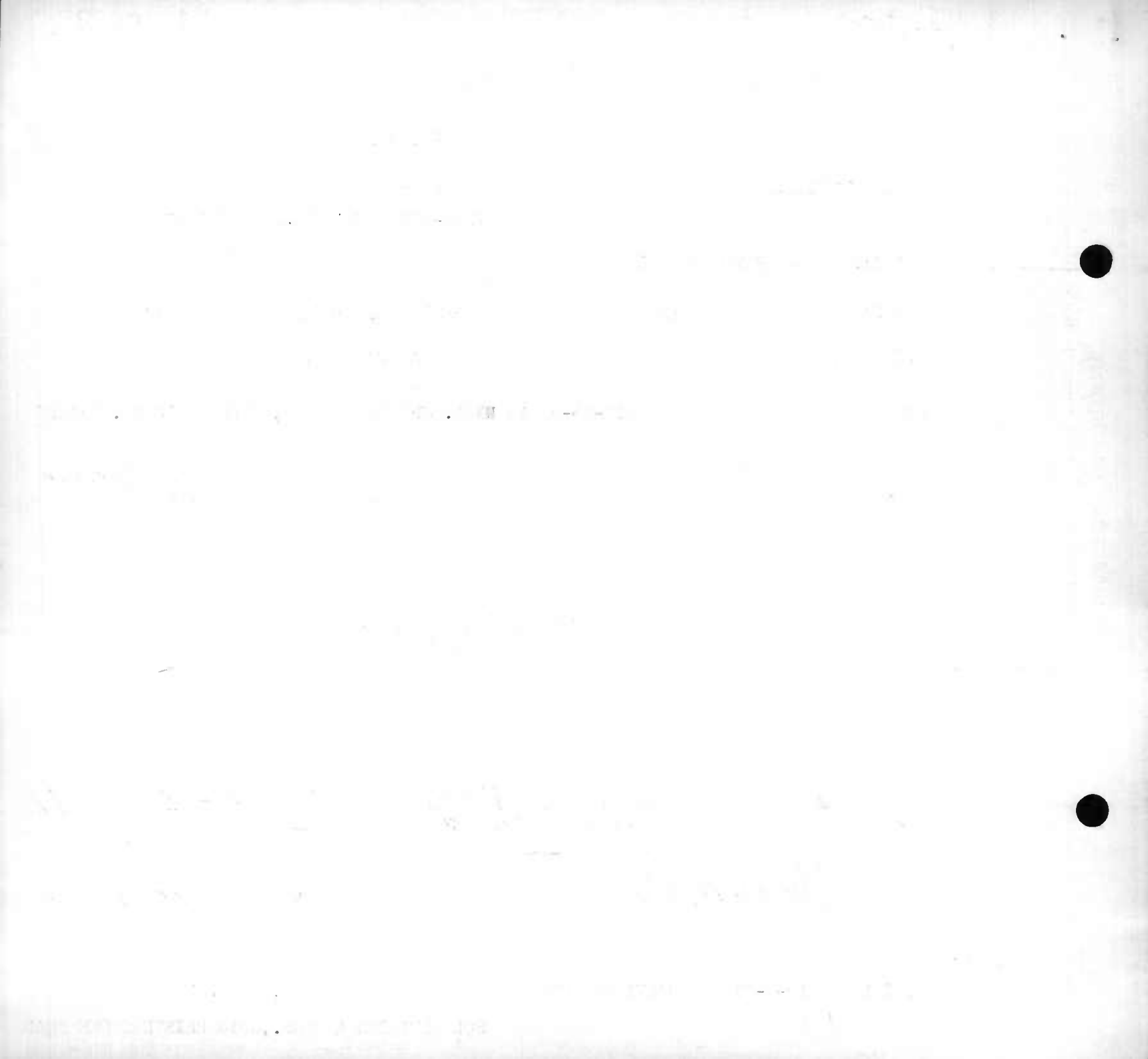




# FUNERAL DIRECTOR: IMPORTANT

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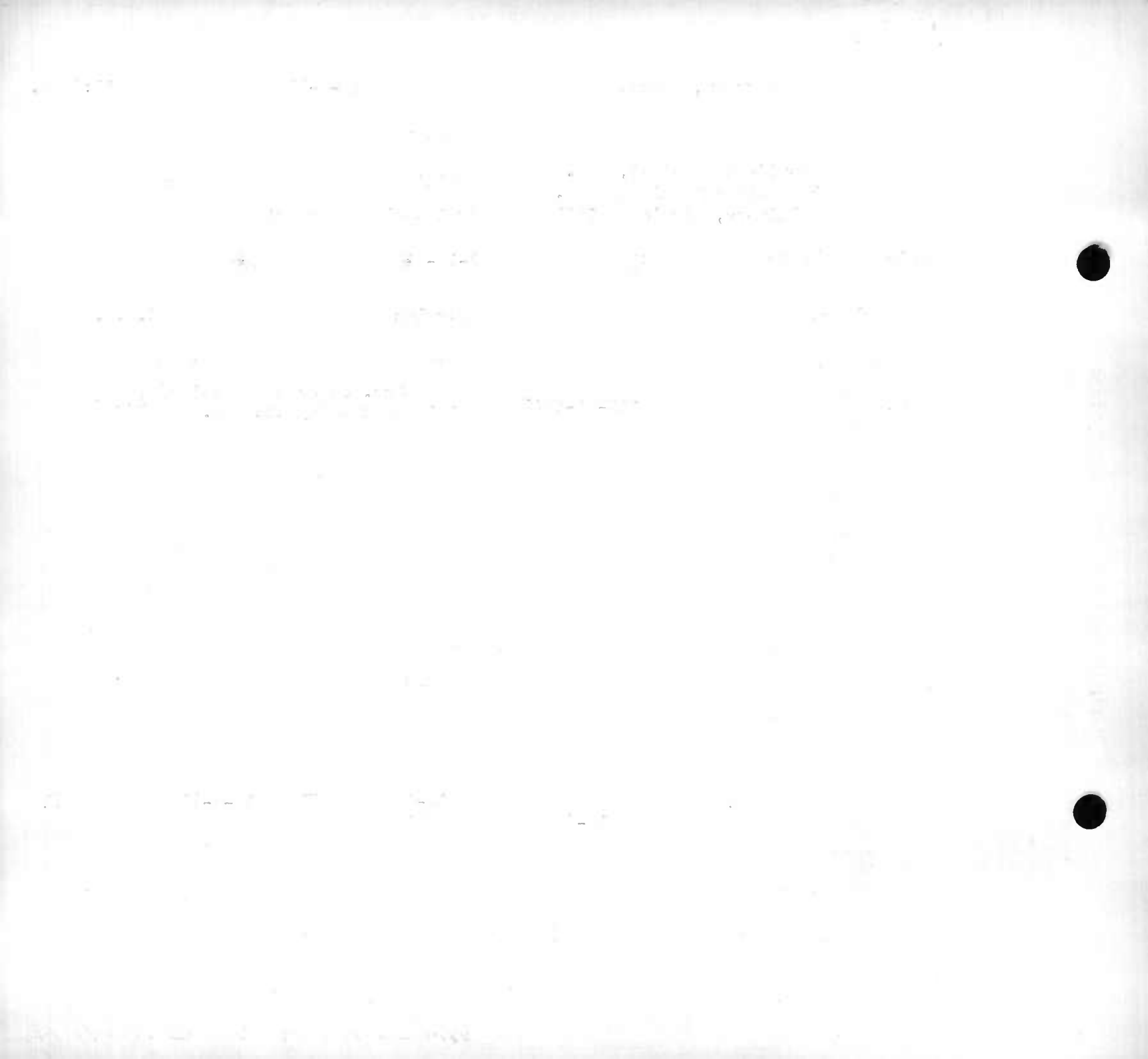
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 9362	
7-555 71 9362				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>FINEMAN, LILLIAN</b>		2. DATE AND HOUR OF DEATH <b>OCT. 3, 1971 6:30 A. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL</b> <b>42</b>			4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1301</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2502-2510 EUTAW PLACE #21217</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
13. FATHER'S NAME <b>JACOB WALDER</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
14. MOTHER'S MAIDEN NAME <b>ELIZABETH ?</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>218-30-5291A</b>			17. INFORMANT <b>MR. JEROME FINEMAN, 2205 ARDEN RD. #21209</b>		
18. <b>412.4 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardio Vascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (At stating the UNDERLYING CONDITION last.) <b>Debility, old age.</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-18</b> 19 <b>71</b> to <b>10-3</b> 19 <b>71</b> that (we) last saw the deceased alive on <b>10-3-71</b> 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Manfour</b>				23B. DATE SIGNED <b>10-3-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Manfour</b>				23D. ADDRESS <b>SOLE LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-6-71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 8 1971</b>			
25B. NAME OF REGISTRAR <b>Robert E. Galt, Jr.</b>		25C. FUNERAL DIRECTOR <b>SOLE LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9363</span>	
A-536 71 9363					
CERTIFICATE OF DEATH					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)		Anderson, Harry		2. DATE AND HOUR OF DEATH 10-6-71 11:45 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  39		A. STATE Maryland			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc. 2600 Liberty Heights Ave. Baltimore, Maryland 21215		B. COUNTY		1513	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4001 Derby Manor Drive			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-19-04	9. AGE (In years last birthday) 67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Anderson		14. MOTHER'S MAIDEN NAME Harriott <del>Matthews</del> Matthews			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-5947		17. INFORMANT Mrs. Jeanette Reynolds/ 1628 East Lafayette Ave. Sister	
18. <span style="font-size: 1.5em;">185X I</span> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Uraemia due to on admit.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <span style="font-size: 1.5em;">Anemia severe + dehydration</span> DUE TO, OR AS A CONSEQUENCE OF:		on admit.	
		<span style="font-size: 1.5em;">due to Carcinoma Prostate</span>		unknown	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<span style="font-size: 1.5em;">Arteriosclerosis</span>		unknown	
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">10-4</span> 19 <span style="font-size: 1.5em;">71</span> to <span style="font-size: 1.5em;">10-6-71</span> 19 <span style="font-size: 1.5em;">71</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">10-6</span> 19 <span style="font-size: 1.5em;">71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Webster Sewell M.D.</span>				23B. DATE SIGNED 7 Oct 71	
23C. PHYSICIAN'S NAME (Type) WEBSTER SEWELL M.D.		23D. ADDRESS Provident Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 10/11/71	24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		24D. LOCATION Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 8 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Wm C. MARCH 928 E North Ave	



# FUNERAL DIRECTOR: IMPORTANT

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<b>B-560</b> BIRTH NO. <u>71 9364</u>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <u>71 9364</u>	
1. NAME OF DECEASED (Type or Print) <u>RAYNOR HATTIE</u>			2. DATE AND HOUR OF DEATH <u>10-6-71 10:40 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Anturan Hospital of Maryland</u> <u>730, Ashburn St., Baltimore - MD-21216</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1538</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3313 Poplar St</u>		
5. SEX <u>Female</u> 6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-3-82</u> 9. AGE (In years last birthday) <u>87</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MT. OLIVE, N.C.</u>	
13. FATHER'S NAME <u>DAVE COX</u>			14. MOTHER'S MAIDEN NAME <u>HANNAH COX</u>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary Harris</u> ADDRESS <u>33035 Dorchester Rd.</u>	
18. <u>43691</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CVA (Cerebrovascular accident)</u> (B) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>CVA</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>he</u> (this hospital) attended the deceased from <u>10-4-</u> 19 <u>71</u> to <u>10-6-</u> 19 <u>71</u> that (I) <u>we</u> last saw the deceased alive on <u>10-6-</u> 19 <u>71</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> M.D.				23B. DATE SIGNED <u>10-6-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>JASON SAMUEL M.D.</u>				23D. ADDRESS <u>Anturan Hospital of Maryland</u> <u>730, Ashburn St., Baltimore - MD-21216</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-11-71</u>		24C. NAME OF CEMETERY OF CREMATORY <u>Arbutus Mem. Pk.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 8 - 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u>		25C. FUNERAL DIRECTOR <u>Morton Diett F.H. 1701 - HAWKINS ST.</u>			

6/11/71 - Adm.

3506 Forest PK Ave.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

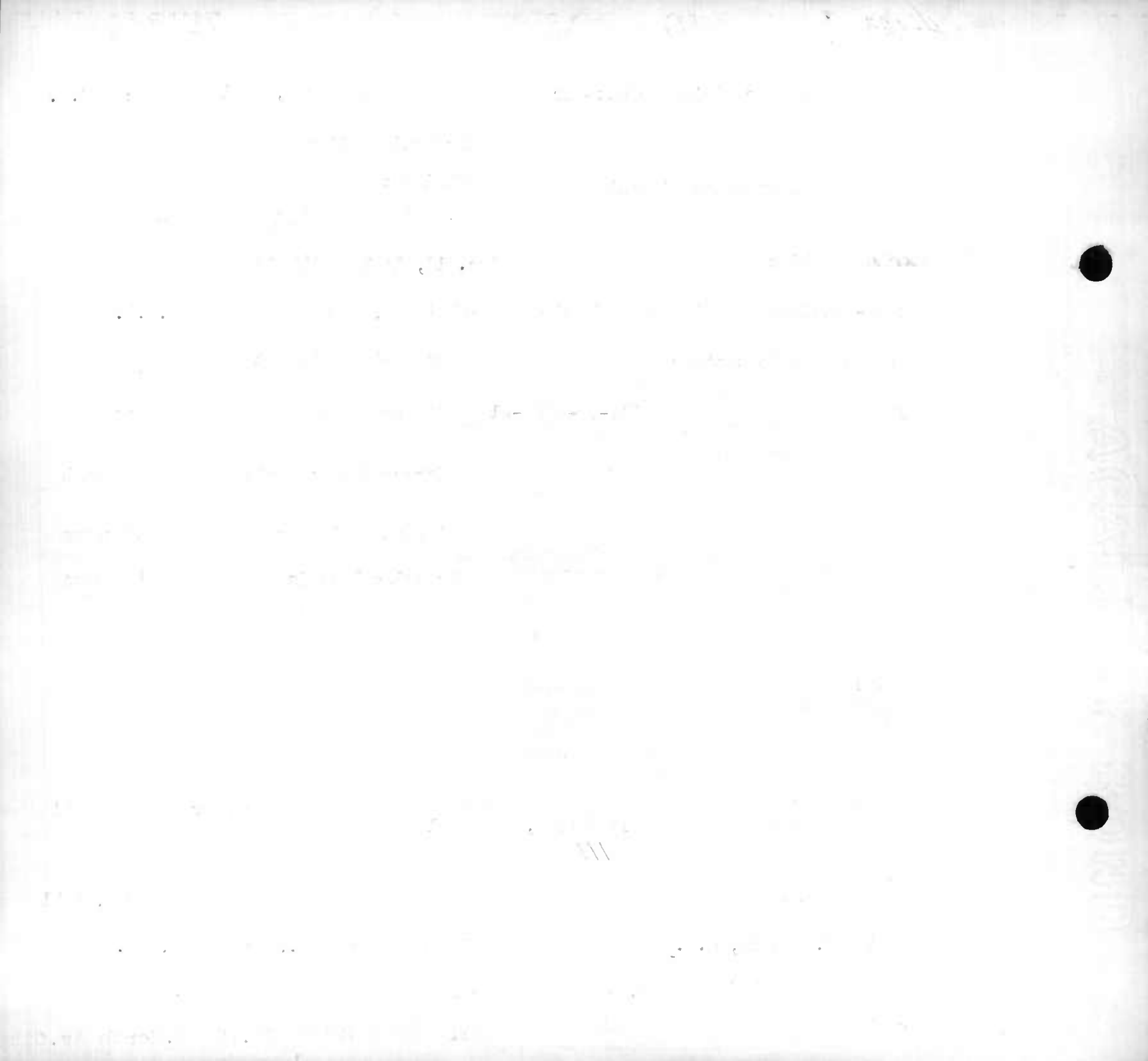
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>71 9365</b>	
BIRTH NO. <b>8-530 71 9365</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>SMITH, HARRY.</b>		2. DATE AND HOUR OF DEATH <b>10/6/71 12-07 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 LUTHERAN HOSPITAL OF MARYLAND</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1607</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2749 WINCHESTER STREET.</b>	
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-25-10</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (in years last birthday) <b>75</b>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>William H. Smith</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. MOTHER'S MAIDEN NAME <b>Maagie Smith</b>		17. INFORMANT <b>Mary Jackson - 718 Cedar Ave 21218</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>817-03-9981</b>	
18. <b>43619 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>C.V.A.</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2. Days</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>9/29/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>STONE IN BLADDER.</b>	
20A. AUTOPSY? (Yes or No) <b>Yes.</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. HOW DID INJURY OCCUR?	
21F. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (if this hospital) attended the deceased from <b>9/24/71</b> to <b>10/6/71</b> and that (if we) last saw the deceased alive on <b>10/6/71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Sein Lwin, M.D.</b>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		25D. ADDRESS	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

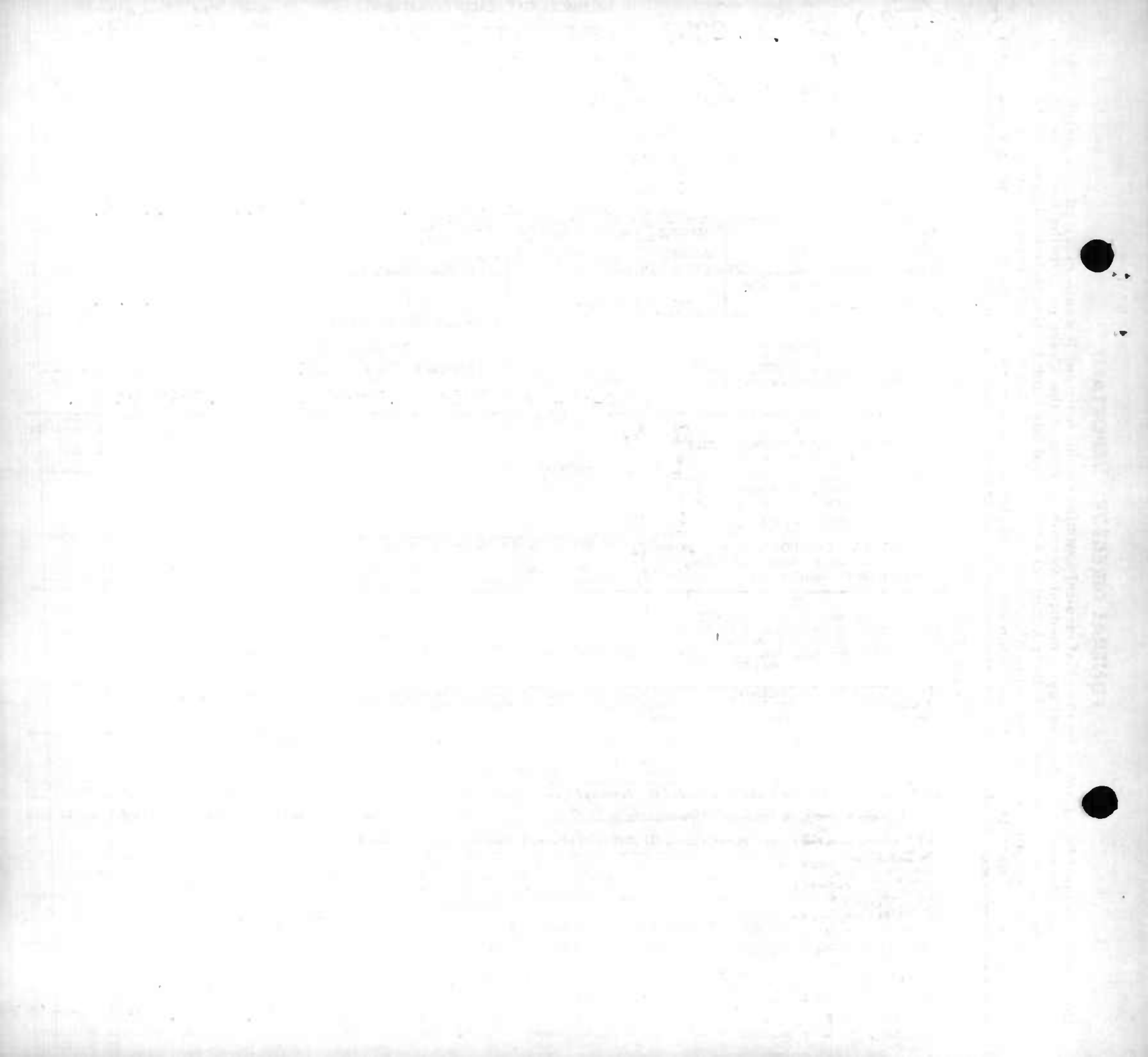
A-123 71 9366		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 9366	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Sister Miriam Hofstetter		October 6, 1971 3:45 P.M. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 94 Villa Saint Michael		Maryland City			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4000 Forest Hill Road - 21207			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 13, 1897	9. AGE (in years last birthday) 74 73	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher - retired		10B. KIND OF BUSINESS OR INDUSTRY Sister of Charity		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Louis Eugene Hofstetter		14. MOTHER'S MAIDEN NAME Mary Gertrude Albert		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-54-0256-J1		17. INFORMANT Sister Andrea same address	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF:  (B) Diabetes mellitus DUE TO, OR AS A CONSEQUENCE OF:  (C) Arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month  10 years  12 years	
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1959 to 1971 that (I) (we) last saw the deceased alive on October 5, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.					
23A. SIGNATURE Damian P. Alagia		23B. DATE SIGNED October 6, 1971		23C. PHYSICIAN'S NAME (Type) Damian P. Alagia, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/8/71		24C. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery	
25A. DATE REC'D BY HEALTH DEPT. OCT 12 1971		25B. NAME OF REGISTRAR Stewart & Bowen		25C. FUNERAL DIRECTOR STEWART & BOWEN CO.	
24D. LOCATION Emmitsburg, Maryland		24E. LOCATION City, town, or county (State)		25D. ADDRESS 108 W. North Av. City	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

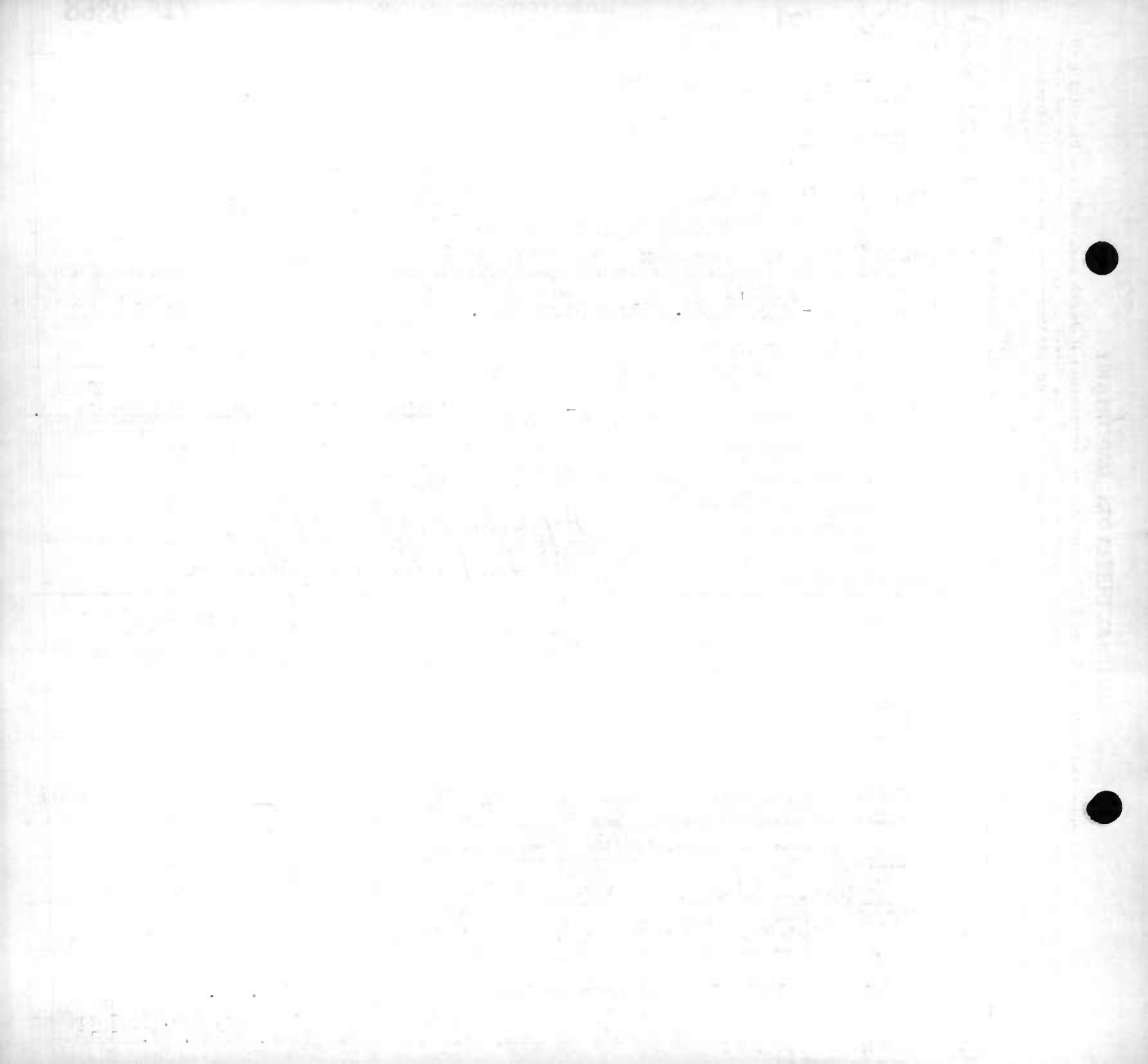
K-620 71 9367		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 9367	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Minnie Kraus</i>		WILHELMINA KRAUS		2. DATE AND HOUR OF DEATH <i>OCT 10, 1971 4:30 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALTO.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Edgewood Nursing Home</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>6000 Bellona Ave Balto, Md-21206</i>		C. CITY OR TOWN <i>Balto.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5/11/88</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired-Owner</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Millinery</i>		11. BIRTHPLACE (State or foreign country) <i>Balto, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Louis Kraus</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Thon</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>J1 220-44-4989</i>		17. INFORMANT <i>Sister:</i>		ADDRESS <i>21202</i>	
18. <i>412.41E88</i>		CAUSE OF DEATH <i>Cerebro-Vascular Accident</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Cardio Vascular Disease</i>				<i>10 yrs</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Stroke</i> DUE TO, OR AS A CONSEQUENCE OF:					
		(C) <i>Fracture (Left Hip)</i>				<i>6 weeks</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A)							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <i>Home</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>1040 N Calvert St</i>			
21D. TIME OF INJURY (APPROX.) <i>9-5-71 8PM</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>fell at home</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>November 10 1969</i> to <i>October 10 1971</i> that (I) (we) last saw the deceased alive on <i>October 8th 1971</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Philip D. Flynn M.D.</i>				23B. DATE SIGNED <i>10/20/71</i>		23C. PHYSICIAN'S NAME (Type) <i>Philip D. Flynn M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/13/71</i>		24C. NAME of CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 12 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR <i>STEWART &amp; MOWEN CO.</i>		ADDRESS <i>108 W. North Ave (1)</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-450 71 9368				BALTIMORE CITY HEALTH DEPARTMENT		71 9368	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Allen, Louise M				Sep. 5 71 11:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
37 Mercy Hospital				Maryland 381			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				273 Herring ct.			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		White				4-18-05	
9. AGE (in years last birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
66		Housewife - Nurse		Mt. Wilson State Hosp.		Pa.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
American				John E. Evans			
14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
Alice L. Cairns				no			
16. SOCIAL SECURITY NO.				17. INFORMANT			
				Christine Daniel (dghtr) 8027 Lansdale Rd.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
402X1				Congestive heart failure.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				Hypertensive heart (700 pm)			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				Mitral + aortic stenosis			
				(C) Generalized atherosclerosis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Sep. 4 19 71 to Sep. 5 19 71 that (I) (we) lost saw the deceased alive on Sep 5 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
John Ohe ND				10/5/71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
TOHRV OHE ND				Mercy Hospital, Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/7/71		Oak Lawn Cemetery		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 12 1971		R. L. O. J. B. 20 0 0 0		Schimunek Funeral Homes, Inc.		3331 Brehms Lane, Balto. Md. 21213	



E-436 71

9369

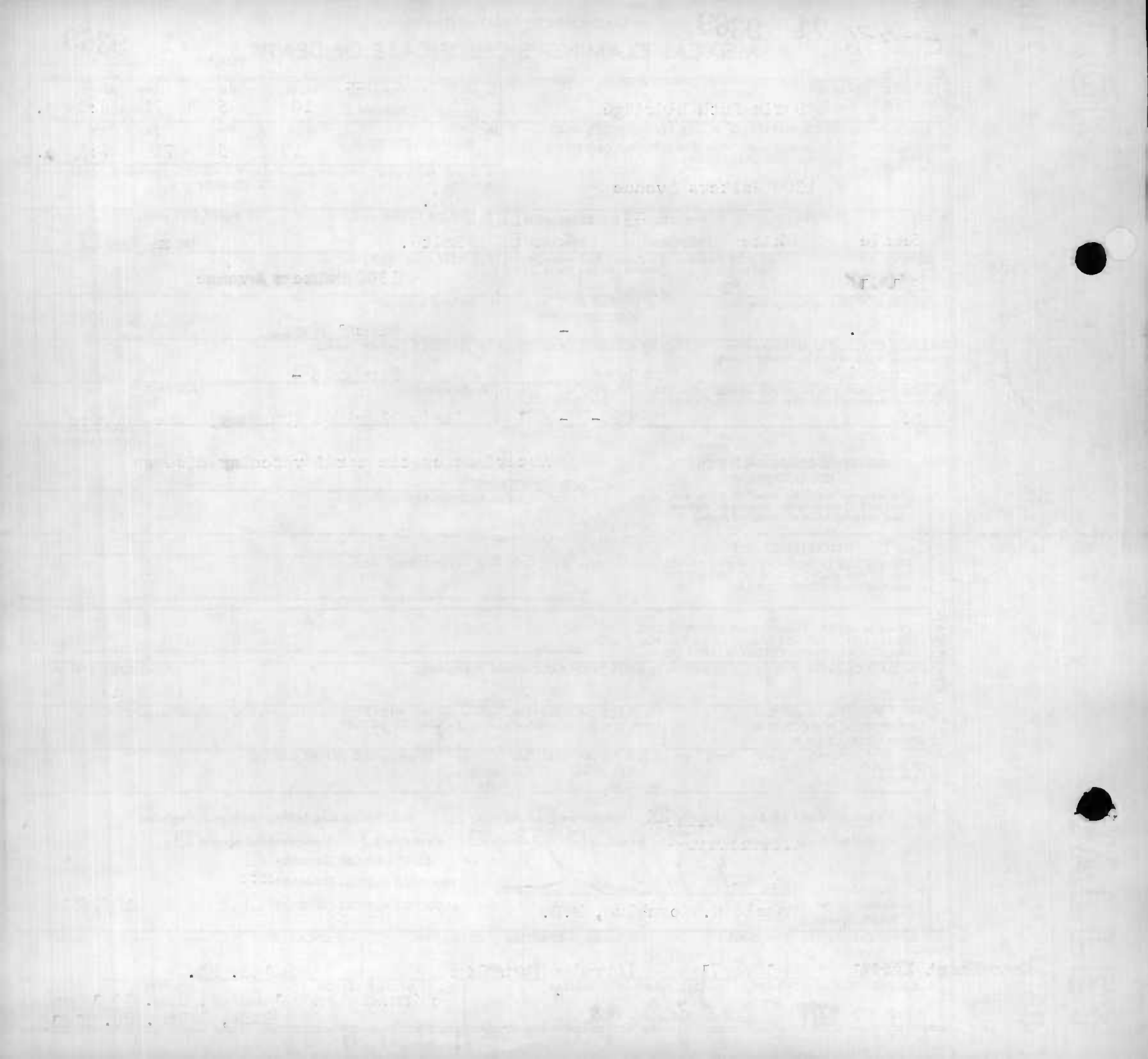
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 9369  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Doris Ruth Eldridge		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 10 5 71 6:30 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1300 Walters Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 5 71 6:30 p.m.	
5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Md. B. COUNTY 2748			
6. SEX female	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.
9. DATE OF BIRTH 2/19/18		10. AGE (In years last birthday) 53	E. STREET AND NUMBER 1300 Walters Avenue
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? -	13. FATHER'S NAME Wencel Novak
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		14B. KIND OF BUSINESS OR INDUSTRY at home	15. MOTHER'S MAIDEN NAME Margaret -
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 220-09-1001	18. INFORMANT Louis Eldridge (husband) same address
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/6/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/8/71	
24C. NAME OF CEMETERY or CREMATORY Lorraine Mausoleum		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 12 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213			

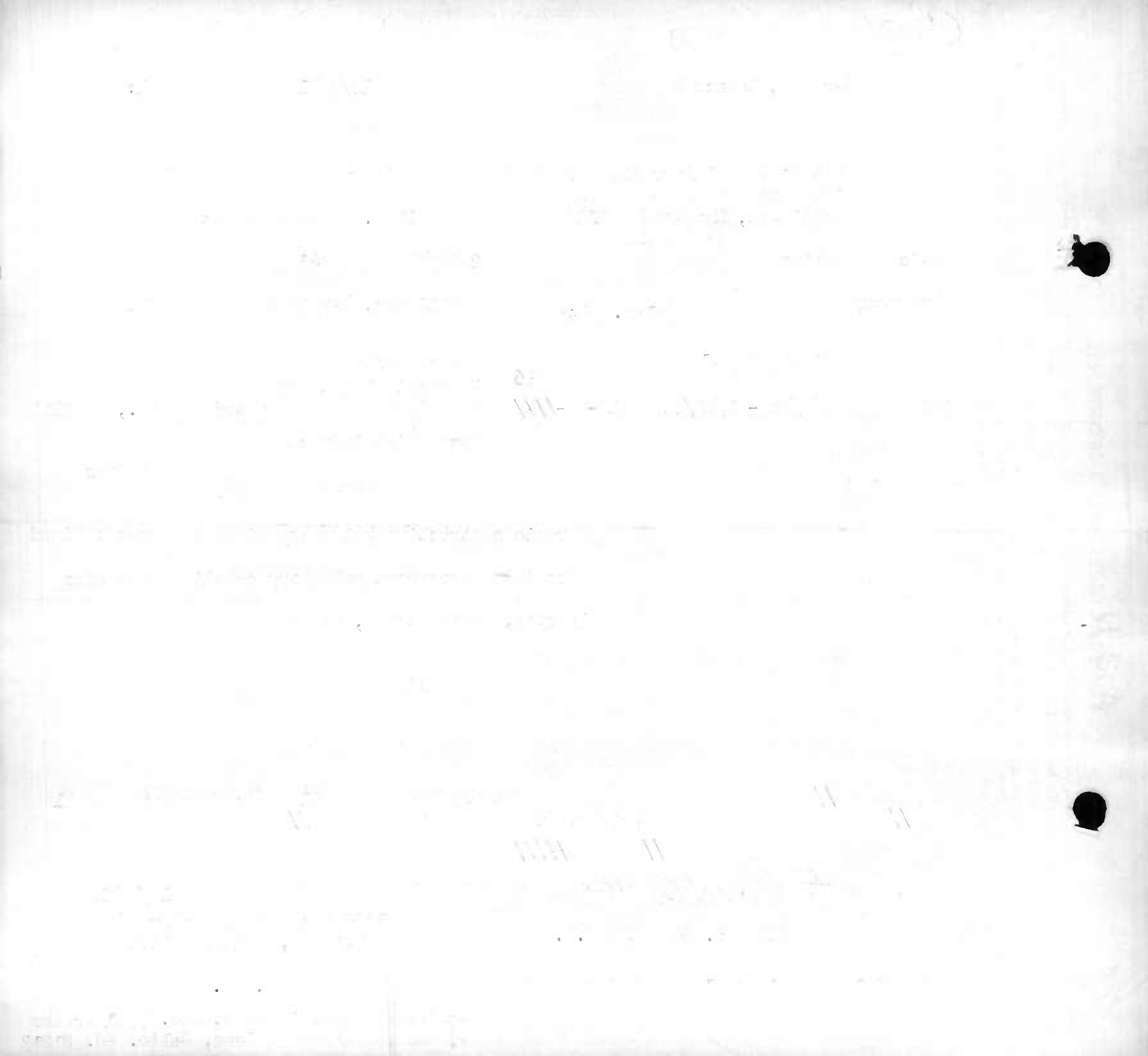




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
BIRTH NO. <span style="float: right;">71 9370</span>					REG. NO. <span style="float: right;">71 9370</span>				
1. NAME OF DECEASED (Type or Print) <b>CARNEAL, Horace E</b>					2. DATE AND HOUR OF DEATH <b>10/5/71 11:30 A</b> M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2634</b>				
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>					C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>5012 E. Preston Street</b>									
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/28/08</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Frank Carneal</b>					14. MOTHER'S MAIDEN NAME <b>Cora Davis</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 2/7/44 - 1/19/46</b>			16. SOCIAL SECURITY NO. <b>8946 218-07-8816</b>		17. INFORMANT <b>VA Hospital Records</b> ADDRESS <b>3900 Loch Raven Boulevard Balto., Md 21218</b>				
18. <b>410.0 14250.9</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarct</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD and H CVD</b> (B) <b>Chronic obstructive pulmonary disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Possible recurrent pulmonary emboli</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>undetermined</b> <b>6 months</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes, Hypertension, old CVA</b>									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <b>1/1</b> (this hospital) attended the deceased from <b>October 2nd 19 71</b> to <b>October 5th 1971</b> that <b>1/1</b> (we) last saw the deceased alive on <b>October 5th 19 71</b> and that in <b>1/1</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>1/1</b> (We) (did) <b>(did not)</b> view the body after death.									
23A. SIGNATURE <b>Jaime F. Caselles M.D.</b>					23B. DATE SIGNED <b>10/5/71</b>			23C. PHYSICIAN'S NAME (Type) <b>JAIME F. CASELLES M.D.</b>	
23D. ADDRESS <b>3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/8/71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Schimmunek Funeral Homes, Inc.</b>		ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9371</u>	
BIRTH NO. <u>M-610 71 9371</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Gerald J. Murphy, Sr.</u>			2. DATE AND HOUR OF DEATH <u>October 8, 1971</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>903</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>643 E. 36th Street</u>		
5. SEX <u>M.</u>	6. RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/3/16</u>	9. AGE (In years lost birthday) <u>55</u>	10. Under 1 Yr. Months: _____ Days: _____ 11. Under 24 Hrs. Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Deputy Sheriff</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Gerald A. Murphy</u>			14. MOTHER'S MAIDEN NAME <u>Eva Maria Wright</u>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes WW71</u>		16. SOCIAL SECURITY NO. <u>218-03-0604</u>		17. INFORMANT ADDRESS <u>Mrs. Gloria M. Murphy 643 E. 36th St.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>410.9 I Coronary Occlusion</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Coronary Heart Disease</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>1 year</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>10/11/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/25</u> 19 <u>71</u> to <u>10/8</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10/8</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harry Deibel M.D.</u>				23B. DATE SIGNED <u>10/8/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>HARRY DEIBEL M.D.</u>				23D. ADDRESS <u>1226 Hanover St. Baltimore Md 21230</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/11/71</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 10 1971</u>			
25B. NAME OF REGISTRAR <u>Robert B. Fisher, Inc.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>John B. Moran, Inc. 3000 E. Baltimore St.</u>			



1

M-255 71 9372

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9372

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
MARY M. MCMAHON		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year October 6, 1971		Month Day Year October 6, 1971		Hour 9:53 P. M.	
6. SEX		7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF		13. FATHER'S NAME	
12-12-1905		65		Maryland		U.S.A.		Michael Curran	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
Homemaker				Mary (Unknown)		No		212-10-5087	
18. INFORMANT		ADDRESS		21. AUTOPSY? (Yes or No)		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
Mr. Francis J. McMahon, 836 Washington Blvd.		21230		No		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.)	
19. CAUSE OF DEATH		20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)									
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
Charles S. Springate, M.D.		Charles S. Springate, M.D.						DATE SIGNED	
								October 7, 1971	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		10-9-1971		Glen Haven Cemetery		GlenBurnie, Anne Arundel Co., Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
OCT 12 1971		Robert E. Fisher, M.D.		Howard H. Hubbard, 4107 Wilkens Ave.		21229			

VS 151-REV. 7/1/68

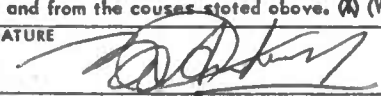
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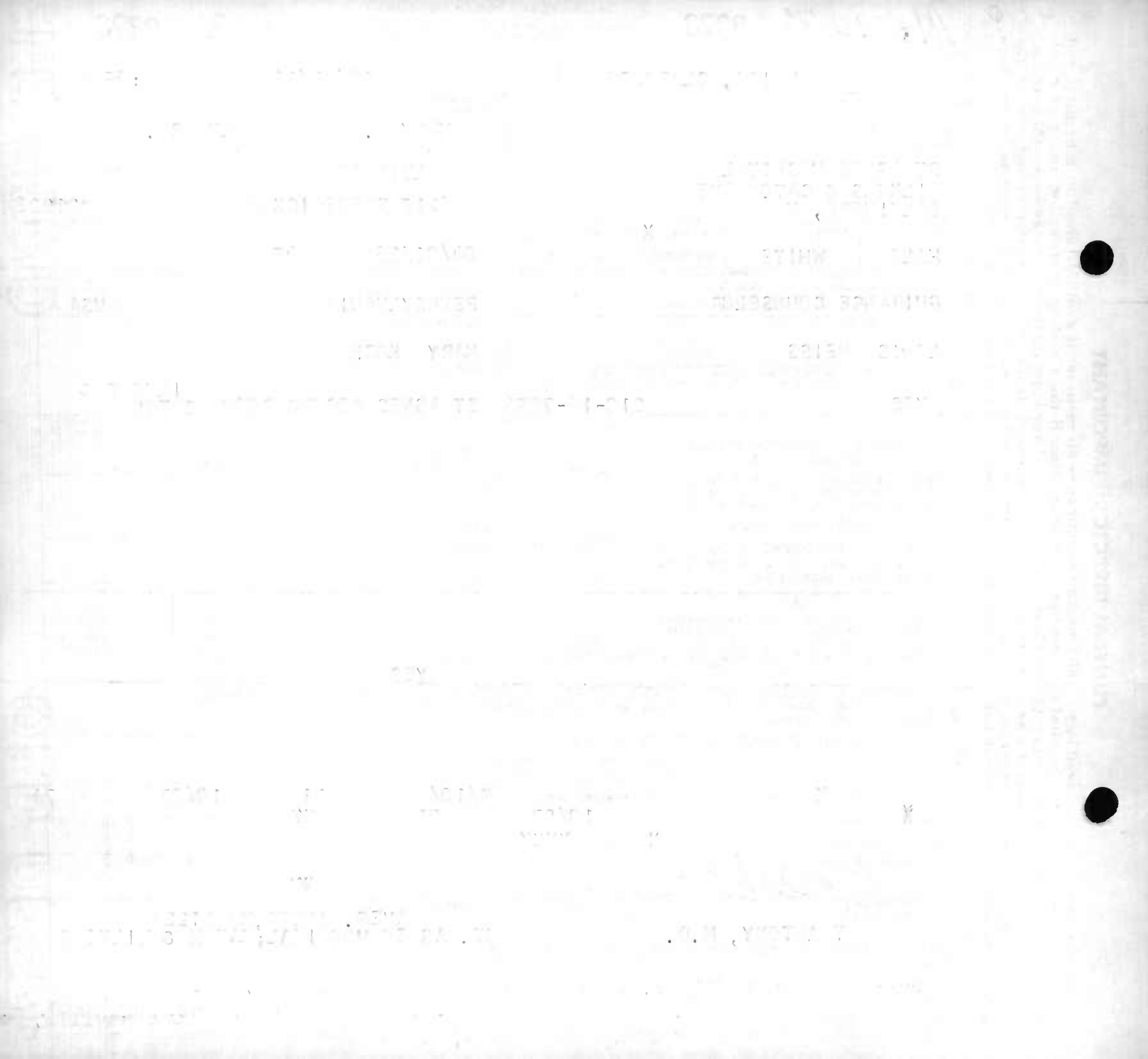
I. R.

*Black & White*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9373</u>	
BIRTH NO. <u>M-200 71 9373</u>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>MEISS, CLARENCE J.</u>		2. DATE AND HOUR OF DEATH <u>10/07/71</u> <u>9:05 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYND.</u> B. COUNTY <u>BALTO CO.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>ST AGNES HOSPITAL</u> <u>WILKENS &amp; CATON AVE</u> <u>BALTIMORE, MD</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>6215 FREDERICK RD</u>		<u>21228</u>	
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>04/01/26</u>	9. AGE (In years last birthday) <u>45</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUIDANCE COUNSELOR</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>LEWIS MEISS</u>		14. MOTHER'S MAIDEN NAME <u>MARY KOCH</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u>		16. SOCIAL SECURITY NO. <u>210-18-7956</u>		17. INFORMANT <u>ST AGNES RECORD ROOM</u>	
				ADDRESS <u>WILKENS &amp; CATON</u>	
18. <u>567.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary embolus</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>9/10/71</u> to <u>10/07/71</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>10/07/71</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <u>T. ANTONY, M.D.</u>		23D. ADDRESS <u>AVES. BALTO, MD 21229</u> <u>ST. AGNES HOSPITAL; CATON &amp; WILKENS</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/11/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Laurel Mem Park</u>	
24D. LOCATION <u>Hazelton, Pa.</u>		24E. ADDRESS <u>Edw. S. MacNabb Sons, Inc.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1971</u>		25B. NAME OF REGISTRAR <u>Edw. S. MacNabb Sons, Inc.</u>		25C. FUNERAL DIRECTOR <u>301 Fred. Rd. Catonsville, Md</u>	





A-40071

9374

BALTIMORE CITY HEALTH DEPARTMENT

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 9374  
REG. NO. \_\_\_\_\_

BIRTH NC.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year October 6, 1971		Hour 11:50 P	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1302 Morling Avenue		3. DATE PRONOUNCED DEAD Month Day Year October 6, 1971		Hour 11:50 P			
6. SEX Male		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH April 13, 1923		10. AGE (In years last birthday) 48		11. BIRTHPLACE (State or foreign country) Md.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME ?		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffer		15. MOTHER'S MAIDEN NAME ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes		17. SOCIAL SECURITY NO. W.W.11		18. INFORMANT Ella F. Healy		ADDRESS 1302 Morling Ave.	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED October 7, 1971	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct 9, 1971		24C. NAME OF CEMETERY or CREMATORY Moreland		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 12 1971		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Paul E. Chenoweth Jr.		ADDRESS 3617 Chestnut Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

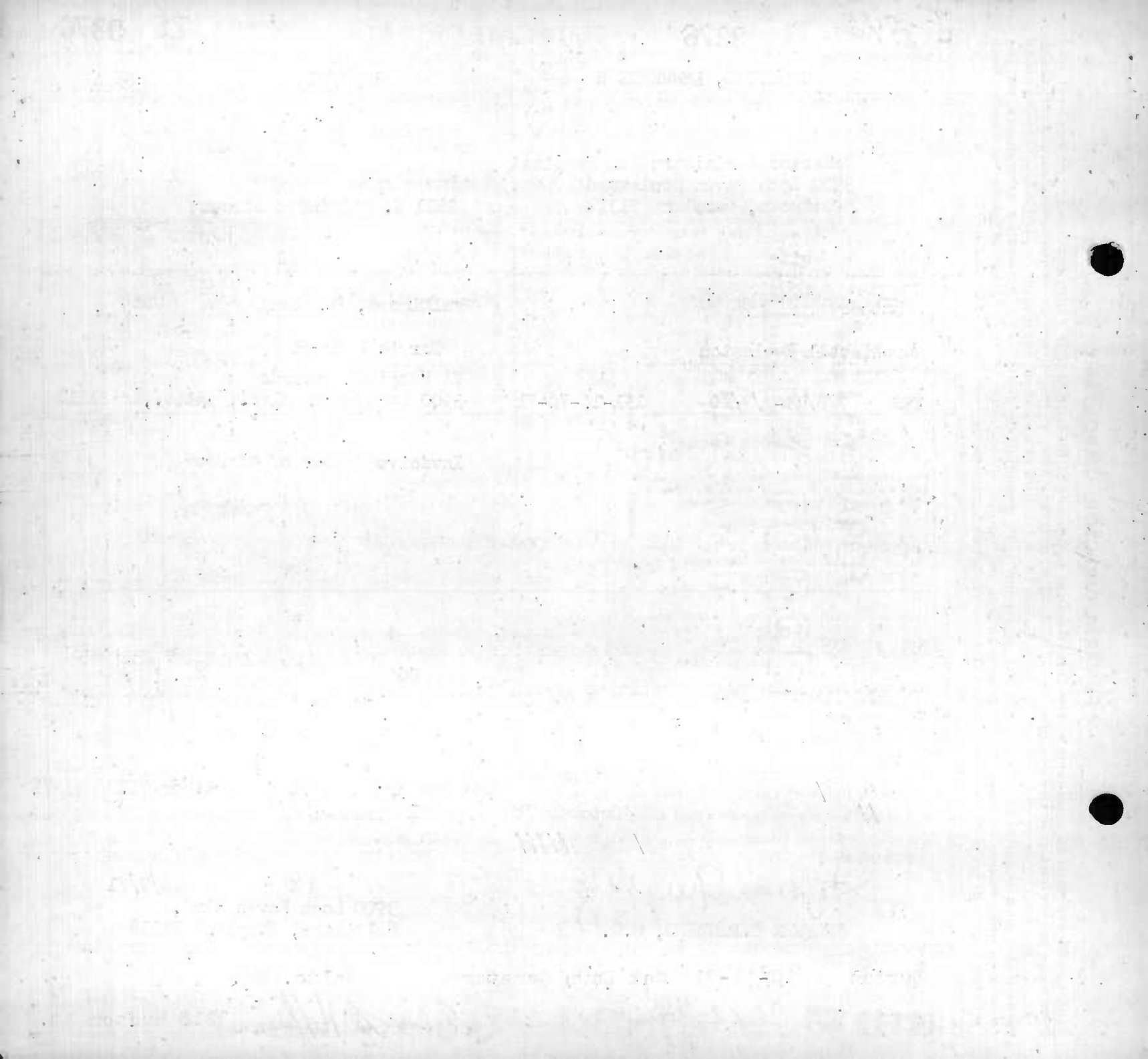
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 9375</b>	
<b>S-6301 9375</b> <b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>SHERWOOD, JAMES LEROY</b>		2. DATE AND HOUR OF DEATH <b>10/7/71 6:55 A</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1107 Newfield Rd</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/18/94</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>auditor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Savannah, Ga.</b>	
13. FATHER'S NAME <b>William Sherwood</b>		14. MOTHER'S MAIDEN NAME <b>Katie McGinley</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>Yes</b> 5/7/18 - 6/7/19		6. SOCIAL SECURITY NO. <b>705-09-00-22</b>		17. INFORMANT <b>VA Hospital Records</b> ADDRESS <b>3900 Loch Raven Blvd., Balto., Md 21218</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the immediate cause, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>584X 4222+ Cardiac arrest</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS giving rise to the above cause (B) Underlying condition (C) <b>Skull fracture</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>It occurred U.A. Shop</b>	
21D. TIME OF INJURY (APPROX.) <b>10-6-71 1:30 A</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>fell off Chair</b>	
22. I certify that <b>11</b> (this hospital) attended the deceased from <b>10/4</b> 19 <b>71</b> to <b>10/7</b> 19 <b>71</b> , that <b>11</b> (we) last saw the deceased alive on <b>10/7</b> 19 <b>71</b> and that in <b>11</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>11</b> (We) (did) <b>11</b> view the body after death.					
23A. SIGNATURE <b>[Signature]</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/8/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>JUAN ZORA M.D.</b>		23D. ADDRESS <b>3900 Loch Raven Blvd. Baltimore, Maryland 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>10/11/71</b>	24C. NAME of CEMETERY or CREMATORY <b>LOUDON PARK</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>EDWARD S. MAC NABB SONS, INC.</b> ADDRESS <b>301 FREDERICK RD CATONSVILLE, MD. 21228</b>	



# FUNERAL DIRECTOR: IMPORTANT

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E-242 71 9376				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9376	
1. NAME OF DECEASED (Type or Print) <b>ECCLESTON, LAWRENCE H</b>				2. DATE AND HOUR OF DEATH <b>10/7/71 6:55 A</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>102</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2911 E. Baltimore Street</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/19/89</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lather</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Archieball Eccleston</b>				
14. MOTHER'S MAIDEN NAME <b>Carrie V Trust</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 7/8/19-7/7/20</b>				
16. SOCIAL SECURITY NO. <b>151-10-76-71</b>			17. INFORMATION ADDRESS <b>VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218</b>				
18. CAUSE OF DEATH <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>188X</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE <b>Invasive Cancer of bladder</b> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <b>10</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>October 3rd 19 71</b> to <b>October 7th 19 71</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>October 7th 19 71</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <b>(did not)</b> view the body after death.							
23A. SIGNATURE <b>Stephen Greenberg</b>				23B. DATE SIGNED <b>10/7/71</b>			
23C. PHYSICIAN'S NAME (Type) <b>STEPHEN GREENBERG, M.D.</b>				23D. ADDRESS <b>3900 Loch Raven Blvd. Baltimore, Maryland 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-11-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Hoffman</b>		25C. FUNERAL DIRECTOR ADDRESS <b>3218 Hudson St.</b>			

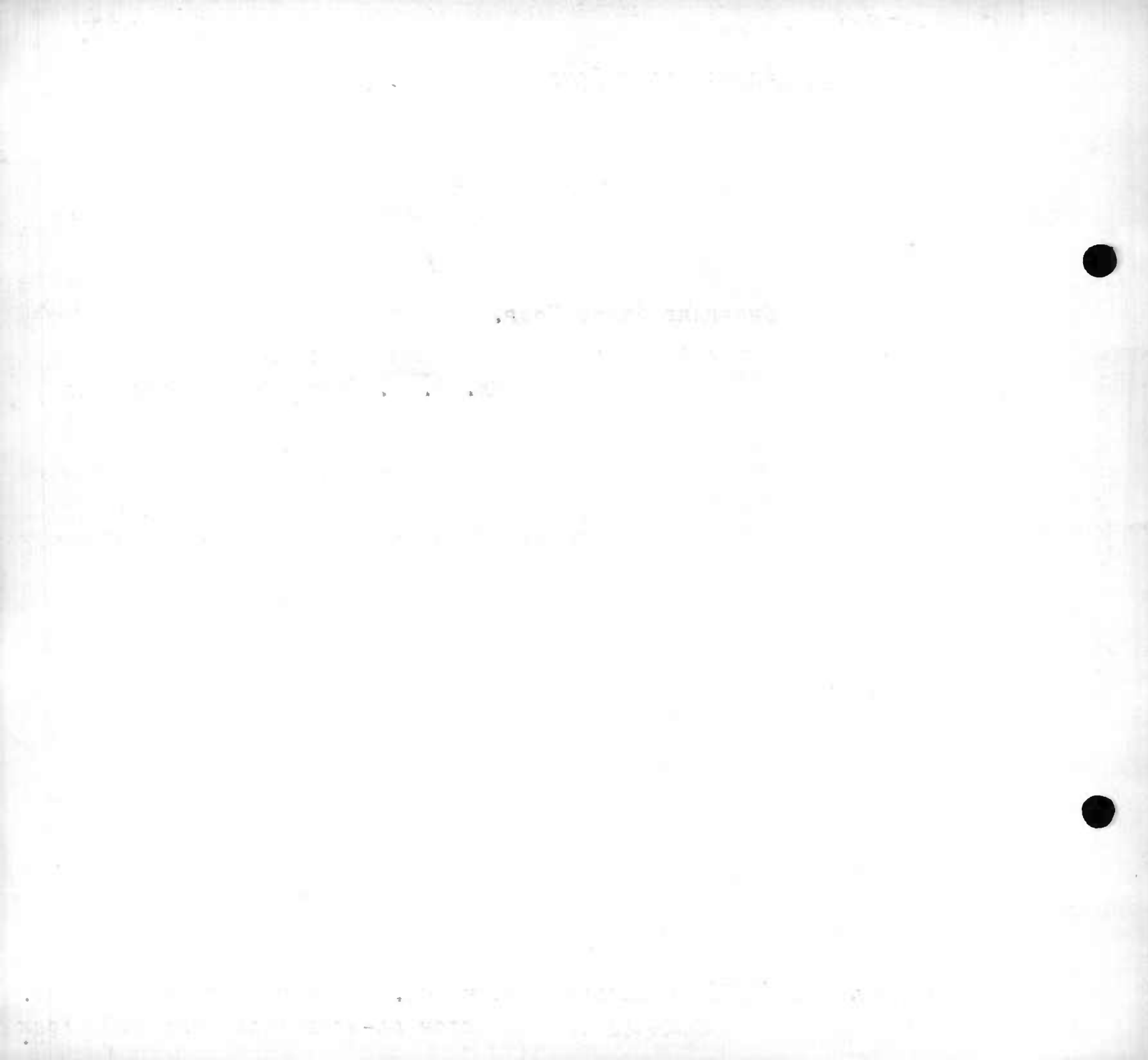




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.5em;">71 9377</span>	
<b>L-520 71 9377</b> <b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">MARTHA ELLEN LONG</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">10/4/71</span> <span style="float: right;">5:30 A.M.</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">CHAURCH HOME AND HOSPITAL</span> <span style="font-size: 1.5em;">35</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">BALTO.</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">BALTIMORE</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">33 MURDOCH RD.</span> <span style="font-size: 1.2em;">21212</span>			
<b>5. SEX</b> <span style="font-size: 1.5em;">F</span>	<b>6. RACE</b> <span style="font-size: 1.5em;">W</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">11/1/13</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.5em;">57</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">SECRETARY SHEPPARD PRATT HOSP.</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">SECRETARY</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">AMERICAN</span>		<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">JOHN N. BOND</span>			
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">SUSAN WILGUS</span>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">—</span>			
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">216-14-176</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">MR. C. M. LONG</span> <span style="font-size: 1.2em;">33 MURDOCK ROAD</span> <span style="font-size: 1.2em;">D. W. MARY</span> <span style="font-size: 1.2em;">BALTO.</span>			
<b>18. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   <div style="text-align: center;">II</div> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> </div> <div style="width: 35%;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <span style="font-size: 1.2em;">1-2 days</span>  <span style="font-size: 1.2em;">21 year</span>  <span style="font-size: 1.2em;">3-4 MONTHS</span> </div> </div>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">3 9/24</span> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">Ca. Lung.</span> <b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">Yes</span>					
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
<b>21F. HOW DID INJURY OCCUR</b>		<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">9/12</span> <span style="font-size: 1.2em;">1971</span> <b>to</b> <span style="font-size: 1.2em;">10/4/71</span> <span style="font-size: 1.2em;">1971</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">10/3/71</span> <span style="font-size: 1.2em;">1971</span> <b>and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>			
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">A. Mehta</span>		<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">10/4/71</span>		<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">A. MEHTA</span>	
<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">Church Home Hosp.</span>		<b>24. BURIAL CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">BURIAL</span> <b>24B. DATE</b> <span style="font-size: 1.2em;">10/7/71</span> <b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">CARROLLS CHURCH CEM.</span> <b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">CHESTNUT RIDGE MD.</span>			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">OCT 12 1971</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">MITCHELL-WIEDEFELD HOME</span> <span style="font-size: 1.2em;">6500 YORK RD.</span>	

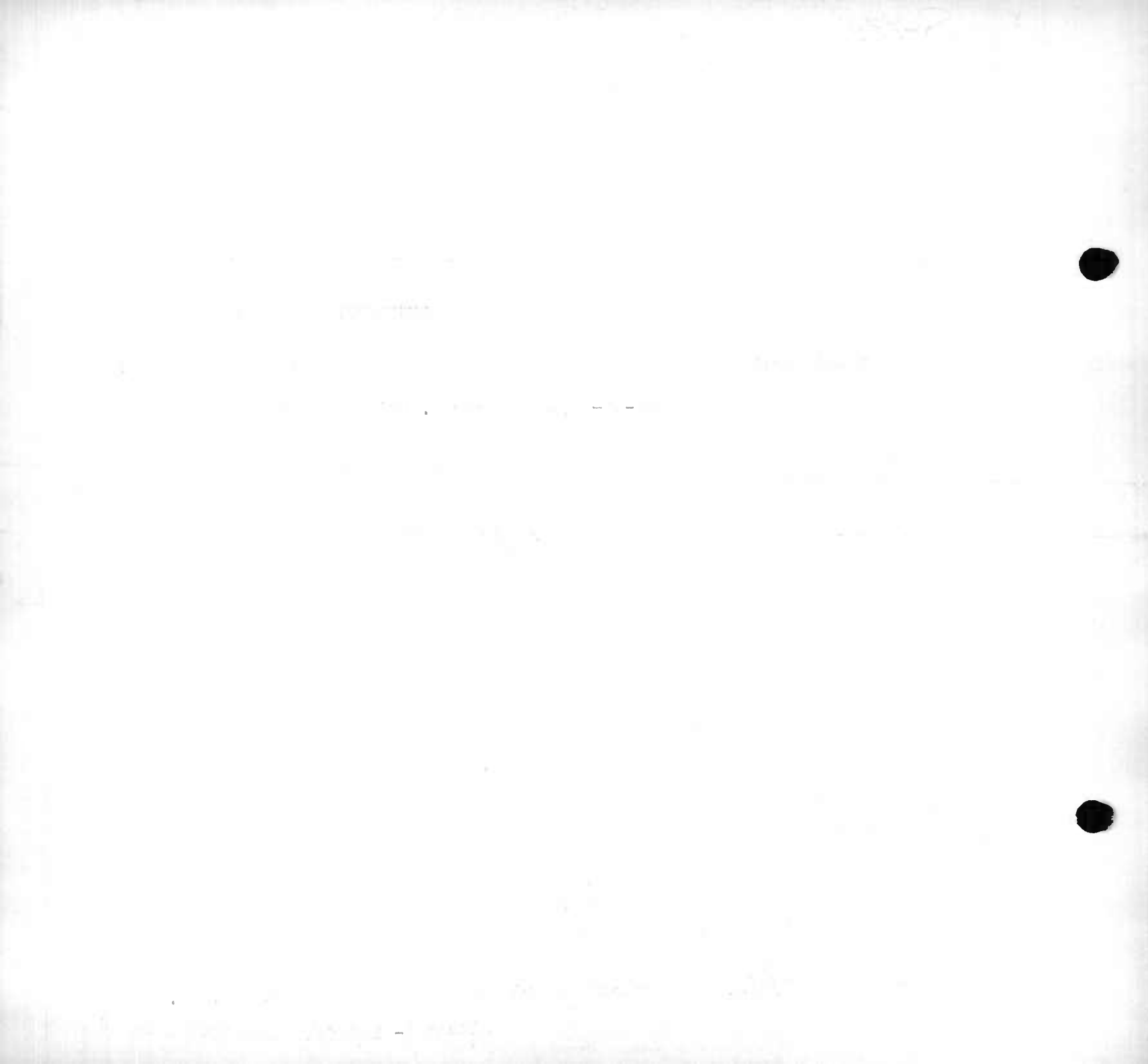




FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 9378</u>	
BIRTH NO. <u>S-134 71 9378</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>SPITTEL, PEARLE, C.</u>		2. DATE AND HOUR OF DEATH <u>10/5/71 4:30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2778</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Hosp. Maryland General</u> <u>1827 Linden Ave.</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>612 Tunbridge Rd.</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-30-02</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H-W.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE (In years last birthday) <u>69</u>
11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Donald Craig</u>		14. MOTHER'S MAIDEN NAME <u>Grace Tate</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>219-10-7392</u>		16. SOCIAL SECURITY NO. <u>219-10-7392</u>	
17. INFORMANT <u>John A. Spittel</u>		ADDRESS <u>612 Tunbridge Road</u>	
18. <u>436.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Stroke</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hypertension</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examined) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>10-5-1971</u>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10-4-1971</u> to <u>10-5-1971</u> that (I) (we) last saw the deceased alive on <u>10-5-1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>C. GAKUBA</u>		23B. DATE SIGNED <u>10-5-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>C. GAKUBA</u>		23D. ADDRESS <u>827, Linden Ave.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/8/71</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Moreland Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Mitchell Wiedefeld</u>		ADDRESS <u>Home 6500 York Rd</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 9379</u>	
BIRTH NO. <u>L-250 71 9379</u>				1. NAME OF DECEASED (Type or Print) <u>LA CON, MARGUERITE M</u>		2. DATE AND HOUR OF DEATH <u>OCTOBER 6, 1971</u> <u>11:05A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>40 ST. AGNES HOSPITAL</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2551</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>FEMALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>10/18/08</u> 9. AGE (In years last birthday) <u>62</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10A. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE CLEMENTS</u>				14. MOTHER'S MAIDEN NAME <u>JUSTICE KRAUSSE CLEMENTS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>216-03-0493</u>		17. INFORMANT <u>Mr. John D. LaCon, 282 Oaklee Village 21229</u> <u>ST. AGNES HOSPITAL RECORDS</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <u>Cardiogenic shock</u> <u>Myocardial infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute interseptal myocardial infarction</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 weeks</u> <u>12 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Rheumatoid arthritis</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 08</u> 19 <u>71</u> to <u>OCTOBER 06</u> , 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>OCTOBER 06</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>10/6/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Jose Apter, M.D.</u>	
23D. ADDRESS <u>BALTIMORE, MD 21229</u> <u>ST. AGNES HOSPITAL; CATON &amp; WILKENS AVES</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-9-1971</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Seiber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>		25D. ADDRESS <u>4107 Wilkens Ave. 21229</u>	

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BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>HOWARD L WELLEN</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>October</b> Day <b>7</b> , Year <b>1971</b> Hour <b>1:50</b> A. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 St. Agnes Hospital</b>				3. DATE PRONOUNCED DEAD Month <b>October</b> Day <b>7</b> , Year <b>1971</b> Hour <b>1:50</b> A. M.			
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2582</b>							
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years lost birthday) <b>27</b>		E. STREET AND NUMBER <b>1017 Parkley Parksley Ave. 21223</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>Hugh E. Wellen</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Draftman</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Catherine Walter</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>216 50 0431</b>		18. INFORMANT <b>Hugh E. Wallen</b>		ADDRESS <b>1017 Parksley Ave. Baltimore, Md 21223</b>	
19. <b>412.41</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type): <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: <b>October 7, 1971</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/10/71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Good Shepherd</b>		24D. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Higinbotham Slack Ellicott City, Md. 21043</b>			

Case 17

U.S. District Court

for the District of Columbia

Case No. 17

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of the Estate of

John

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of the Estate of

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 9381</u>	
BIRTH NO. <u>S-545 71 9381</u>				1. NAME OF DECEASED <u>Josephine Szumlanski</u>		2. DATE AND HOUR OF DEATH <u>10/5/71 7:07 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>CHURCH HOME &amp; HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>US</u>		C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u> 6. RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>2-18-88</u> 9. AGE (In years last birthday) <u>83</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>POLOAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>ANDREW ANTCZAK</u>	
14. MOTHER'S MAIDEN NAME <u>AGATHA (?)</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-03-3129</u>	
17. INFORMANT <u>Frances Szumlanski, Baltimore, Md. 21224</u>				18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Cardiac arrhythmia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD ATRIAL FIBRILLATION</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Fx, D Femur</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
19A. DATE OF OPERATION <u>10/24/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Fx, Rt Femur</u>		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>606 S. Linwood Ave</u>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>4-23-71 9A</u>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>fell off truck</u>		22. I certify that (this hospital) attended the deceased from <u>9/19</u> 19 <u>71</u> to <u>10/5</u> 19 <u>71</u> that (we) last saw the deceased alive on <u>9/5</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <u>W. B. Maniagr</u> 23B. DATE SIGNED <u>10/5/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>WILMA B. MANIAGO M.D.</u>		23D. ADDRESS <u>CHH Church Home &amp; Hospital, Balto. Md.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/9/71</u>	
24C. NAME of CEMETERY or CREMATORY <u>St. Stanislaus Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>John J. Duda</u>		25D. ADDRESS <u>72829 Hudson St. Balto. Md.</u>		VS 150-REV. 1/1/68			

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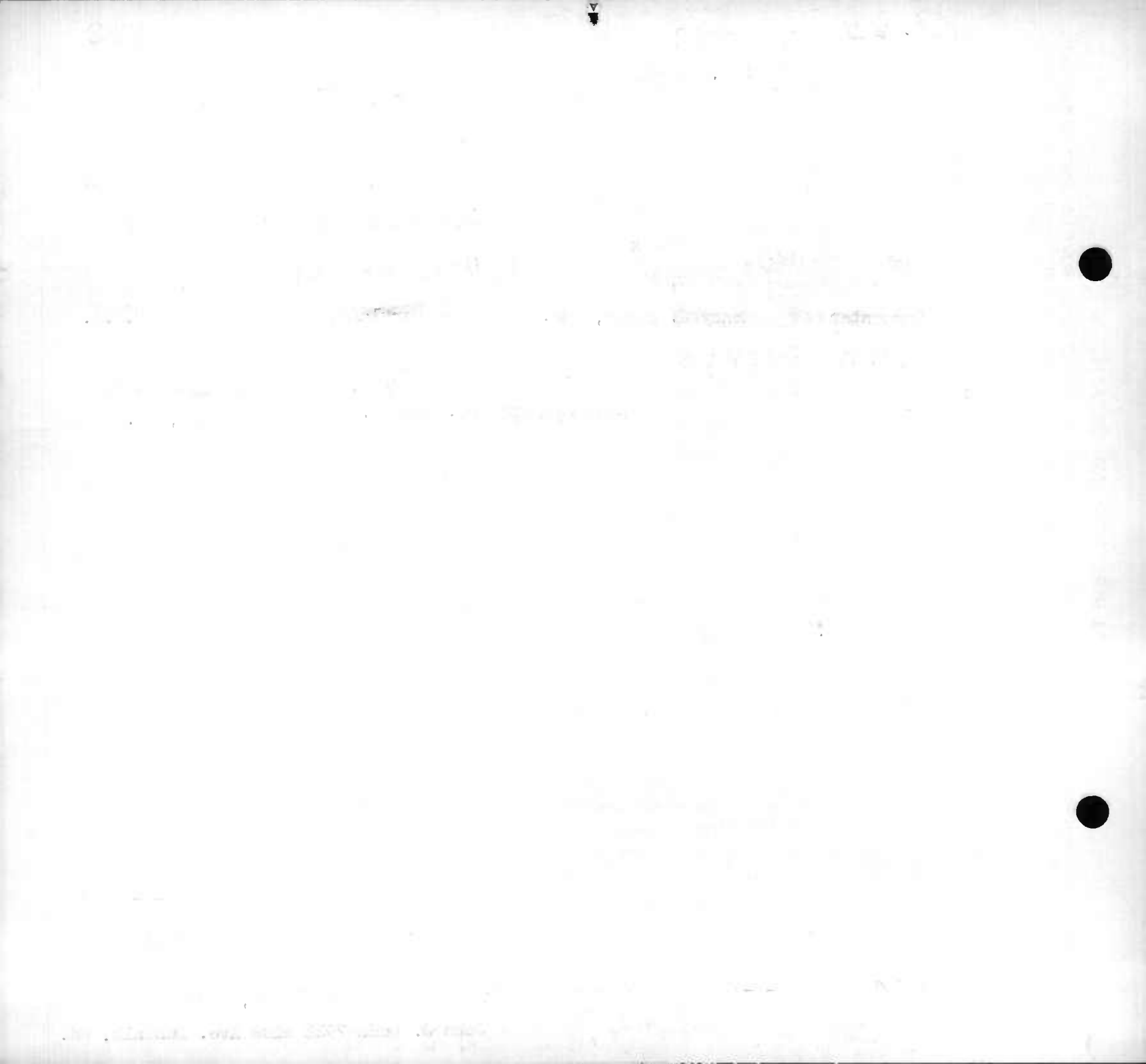
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

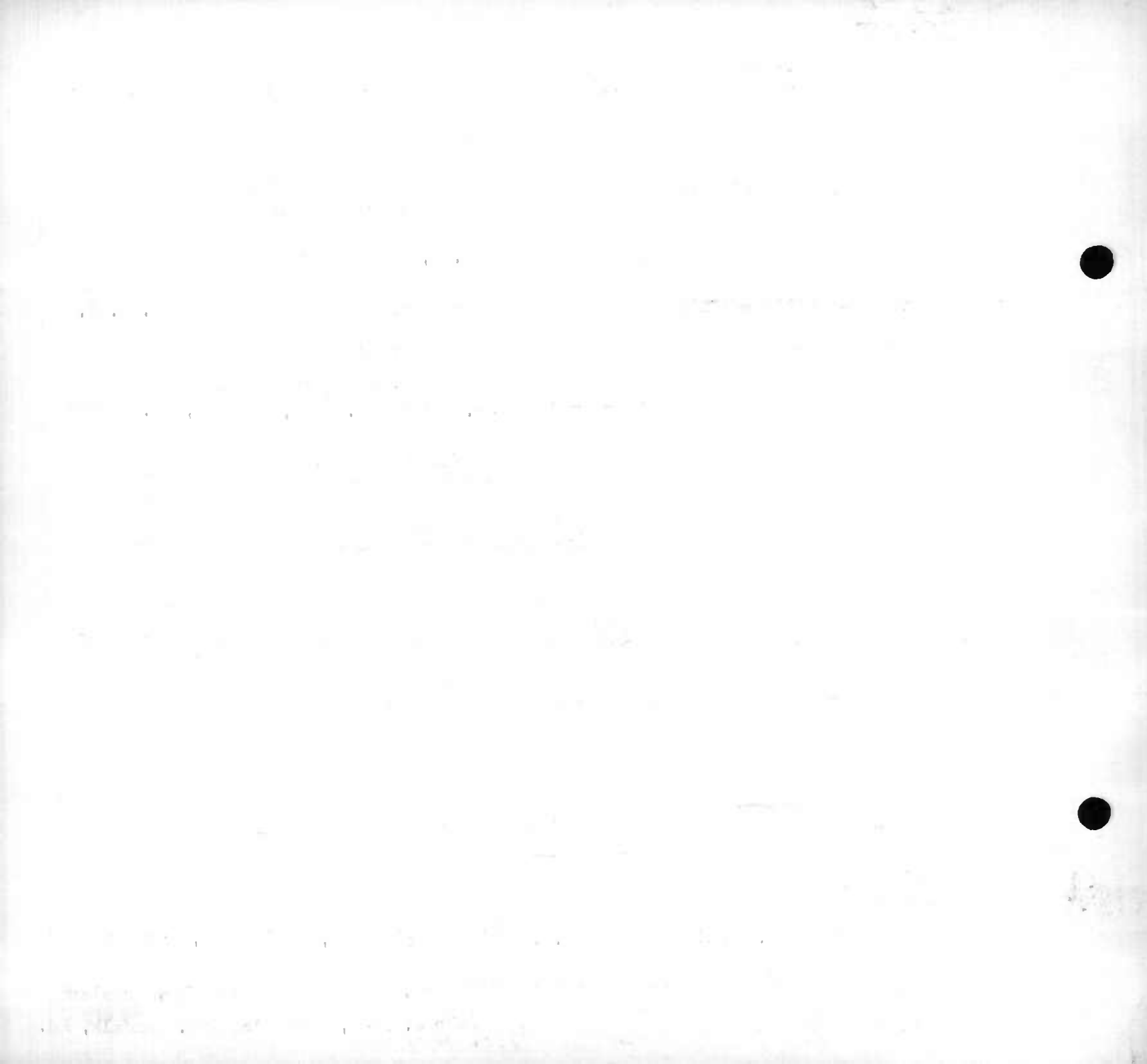
<p><b>G-162</b> 71 9382</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. 71 9382</p>	
<p>BIRTH NO. <b>G-162</b></p>		<p>1. NAME OF DECEASED (Type or Print) <b>Joseph M. Gabris</b></p>	
<p>2. DATE AND HOUR OF DEATH <b>10-7-71 1AM</b></p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>	
<p>4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)</p> <p>A. STATE <b>Mo.</b> B. COUNTY <b>Baltimore</b></p>		<p>5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><b>Church Home &amp; Hospital</b></p>	
<p>6. CITY OR TOWN <b>Dundalk</b></p>		<p>7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>8. STREET AND NUMBER <b>20 WOODLAND AVE. 21222</b></p>		<p>9. SEX <b>Male</b> 10. RACE <b>White</b></p>	
<p>11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>12. DATE OF BIRTH <b>11-11-09</b> 13. AGE (in years lost birthday) <b>61</b></p>	
<p>14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b></p>		<p>15. KIND OF BUSINESS OR INDUSTRY <b>Henry J. Knott, Inc.</b></p>	
<p>16. BIRTHPLACE (State or foreign country) <b>Maryland</b></p>		<p>17. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>	
<p>18. FATHER'S NAME <b>JOHN GABRIS</b></p>		<p>19. MOTHER'S MAIDEN NAME <b>SOPHIA?</b></p>	
<p>20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		<p>21. SOCIAL SECURITY NO. <b>213074873</b></p>	
<p>22. INFORMANT <b>Wife: Mrs. Anna H. Gabris</b></p>		<p>23. ADDRESS <b>20 Woodland Avenue Dundalk, Md. 21222</b></p>	
<p>24. CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE <b>CA of The Lung</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p>		<p>25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>(B) <b>CA of The Lung and Pleural Effusion</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p>		<p>(C) _____</p>	
<p>26. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p>		<p>27. ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>	
<p>28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>		<p>29. MEDICAL CERTIFICATION</p>	
<p>30. DATE OF OPERATION <b>10-7-71</b></p>		<p>31. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>32. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>33. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>34. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>35. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>36. HOW DID INJURY OCCUR?</p>		<p>37. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>38. I certify that (I) (this hospital) attended the deceased from <b>10-3-71</b> to <b>10-7-71</b></p> <p>that (I) (we) last saw the deceased alive on <b>10-7-71</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>		<p>39. SIGNATURE <b>Sayed</b></p>	
<p>40. PHYSICIAN'S NAME (Type) <b>DR Sayed</b></p>		<p>41. ADDRESS <b>Church Home &amp; Hospital</b></p>	
<p>42. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>43. DATE <b>10-9-71</b></p>	
<p>44. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b></p>		<p>45. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b></p>	
<p>46. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b></p>		<p>47. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b></p>	
<p>48. FUNERAL DIRECTOR <b>John J. Duda</b></p>		<p>49. ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b></p>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Z-650 71 9383		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 9383	
1. NAME OF DECEASED (Type or Print) <b>Lawrence Zorn</b>		2. DATE AND HOUR OF DEATH <b>10/5/71</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>90 Gould Nursing Home</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION  <b>90 Gould Nursing Home</b>		C. CITY OR TOWN <b>Dundalk</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Nov. 1, 1885</b>		9. AGE (in years last birthday) <b>85</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Baltimore City</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>City</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>William Zorn</b>		14. MOTHER'S MAIDEN NAME <b>Marie ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-14-9680</b>		17. INFORMANT (Son) <b>1724 Stokesley Road</b> <b>Mr. William L. Zorn, Dundalk, Md. 21222</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>I</b> <b>Artificially Induced Heart Disease</b> <b>you</b> <b>you</b> <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) Grounded Artificially Induced</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>you</b> <b>you</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Chronic Bronchitis, Pulmonary Edema, Renal Urinary Tract Infection.</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <b>3/12/71</b> to <b>10/5/71</b> and that (I) (we) lost saw the deceased alive on <b>3/12/71</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Albert B. Bradley</b>		23B. DATE SIGNED <b>10/5/71</b>		23C. PHYSICIAN'S NAME (Type) <b>ALBERT B. BRADLEY</b>	
23D. ADDRESS <b>M.D. 4900 Belair Road, Baltimore, Maryland</b>		23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/9/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus Cem.</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

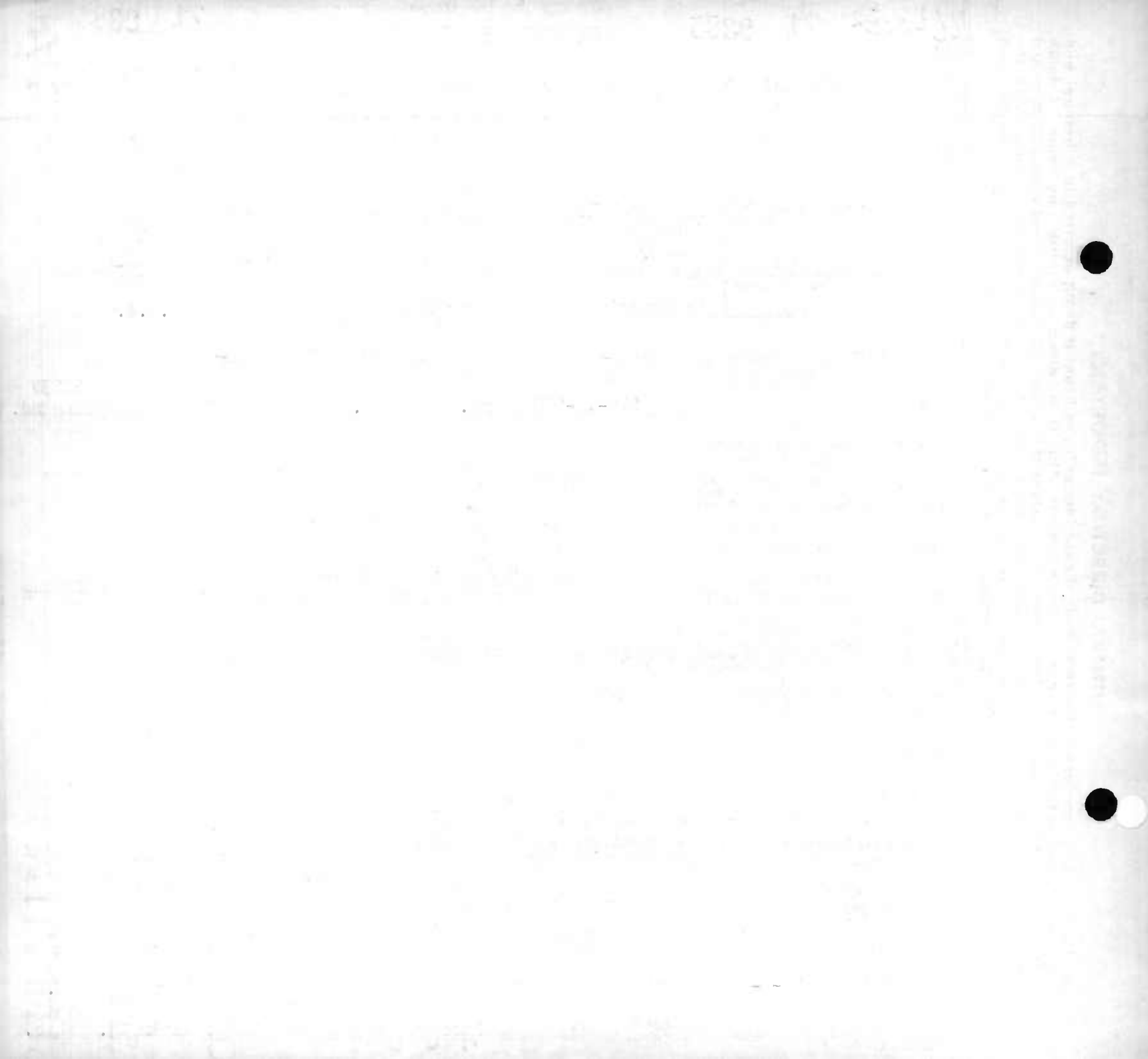
BIRTH NO. <u>R-200</u>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>71 9384</u>	
1. NAME OF DECEASED (Type or Print) <u>Clayton S. Ross</u>		2. DATE AND HOUR OF DEATH <u>10-6-71 1:55 A.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> ADDRESS OR LOCATION <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Dundalk</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-8-96</u>	
9. AGE (In years last birthday) <u>75</u>		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Miner</u>		10B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME <u>George Ross</u>		14. MOTHER'S MAIDEN NAME <u>Roxanne</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>208-10-6545</u>		17. INFORMANT <u>BCH RECORDS: 4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Multiple Injuries</u> <u>Respiratory Insufficiency</u> <u>multiple fractures</u> <u>underlying emphysema</u>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pulmonary Emphysema</u>		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		22. MEDICAL CERTIFICATION		23. MEDICAL CERTIFICATION		24. MEDICAL CERTIFICATION	
21A. DATE OF OPERATION <u>9/27/71</u>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>multiple trauma</u>		21C. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>street</u>		21D. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Wise Ave. + Lynch Rd, Dundalk Md.</u>	
21E. TIME OF INJURY (APPROX.) <u>9 26 71 7:15 PM</u>		21F. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21G. HOW DID INJURY OCCUR? <u>Pedestrian automobile accident</u>		21H. I certify that (I) (this hospital) attended the deceased from <u>9/27</u> 19 <u>71</u> to <u>10-6</u> 19 <u>71</u>	
21I. I (we) last saw the deceased alive on <u>10-6-71</u>		21J. and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <u>Noble Hansen M.D.</u>		23B. DATE SIGNED <u>10-6-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Noble Hansen, M.D.</u>		23D. ADDRESS <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-9-71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Zion Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Marron, Clearfield Co., Penna.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>John J. Duda</u>		25D. ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u>		VS 150-REV. 1/1/68			

Letter from B.C.S. H. M.H.  
10-29-71

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

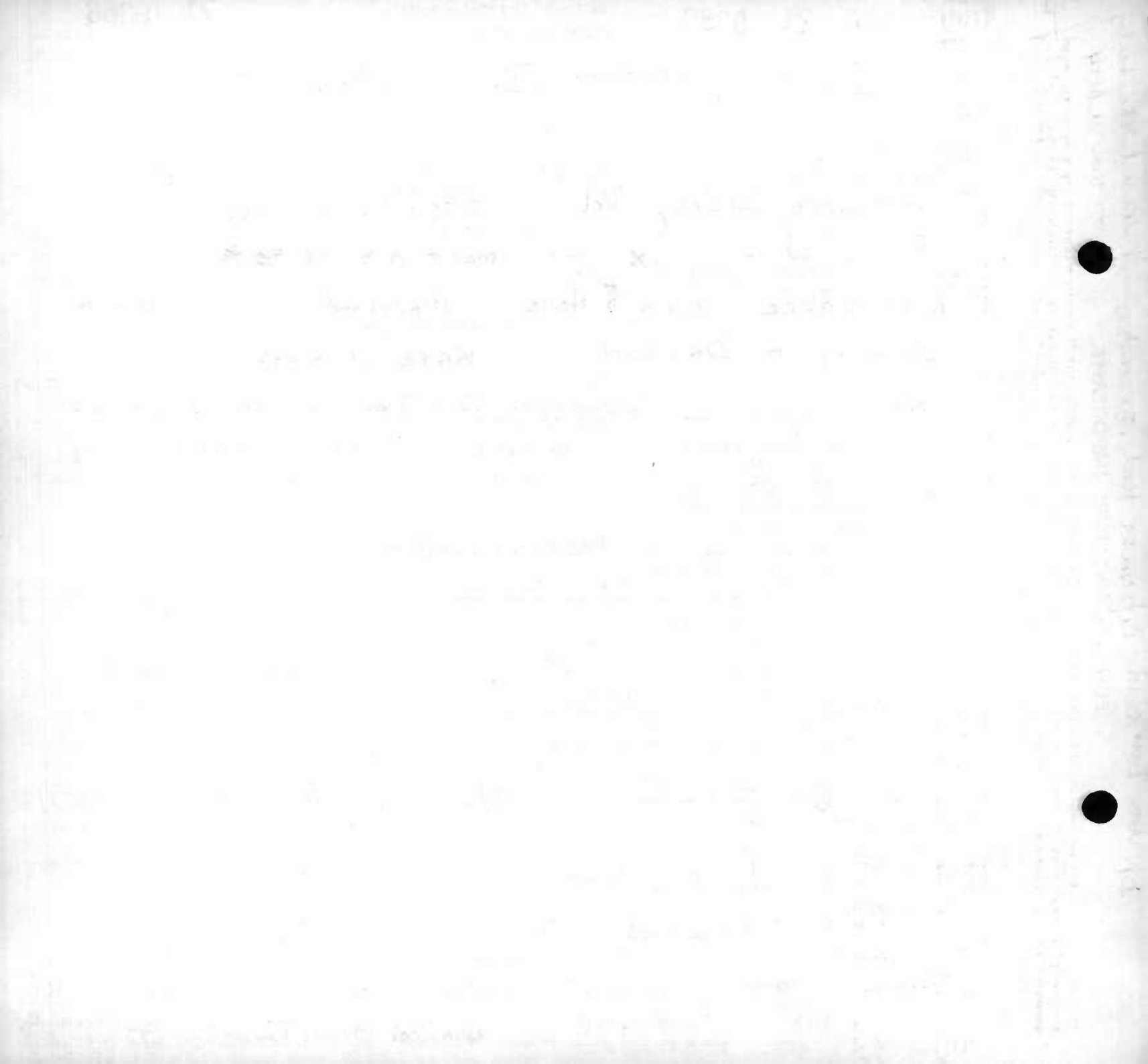
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9385</u>	
<b>BIRTH NO.</b> <u>U2652 71 9385</u>				<b>CERTIFICATE OF DEATH</b>	
<b>1. NAME OF DECEASED</b> (Type or Print) <u>LILLIAN ELIZABETH WARNECKA</u>			<b>2. DATE AND HOUR OF DEATH</b> <u>OCTOBER 7 71 3:15 A. M.</u>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION <u>44 UNION MEMORIAL HOSPITAL</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2735</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>7602 DANIELS AVENUE</u>		
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>12-26-1898</u>	<b>9. AGE</b> (In years last birthday) <u>72</u>	<b>10. Under 1 Yr.</b> Months: Days: <b>11. Under 24 Hrs.</b> Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Homekeeping</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			<b>13. FATHER'S NAME</b> <u>BERNARD JOHN FELDIG</u>		
<b>14. MOTHER'S MAIDEN NAME</b> <u>ANNA HELBIG</u>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) If yes, give war or dates of service <u>No</u>		
<b>16. SOCIAL SECURITY NO.</b> <u>212-18-2706A</u>			<b>17. INFORMANT</b> <u>Mrs. Yvonne A. Eubanks Box 301 E Gumspring Rd. 21237</u>		
<b>18. CAUSE OF DEATH</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>MICROCARDIUM INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ARTHERIO SCLEROSIS</u>		
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
<b>19A. DATE OF OPERATION</b> <u>09/28</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> Indefinite medical examined		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>09/28</u> <b>19</b> <u>71</u> <b>to</b> <u>10/7</u> <b>19</b> <u>71</u> <b>that (I) (we) last saw the deceased alive on</b> <u>10/7</u> <b>19</b> <u>71</u> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>C. VILARIN</u>				<b>23B. DATE SIGNED</b> <u>10/7/71</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>C. VILARIN</u>				<b>23D. ADDRESS</b> <u>3308 2nd Calvert St.</u>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>10-9-71</u>		<b>24C. NAME of CEMETERY or CREMATORY</b> <u>Parkwood Cemetery</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Parkville Baltimore Md.</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>OCT 10 1971</u>			
<b>25B. NAME OF REGISTRAR</b> <u>Robert J. Kelly</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Lassan Funeral Home 7101 Belair Rd. Balto.</u>			





Dr Van Burkum informs: Med. Examiner released the body to the U.M.H. FUNERAL DIRECTOR: IMPORTANT

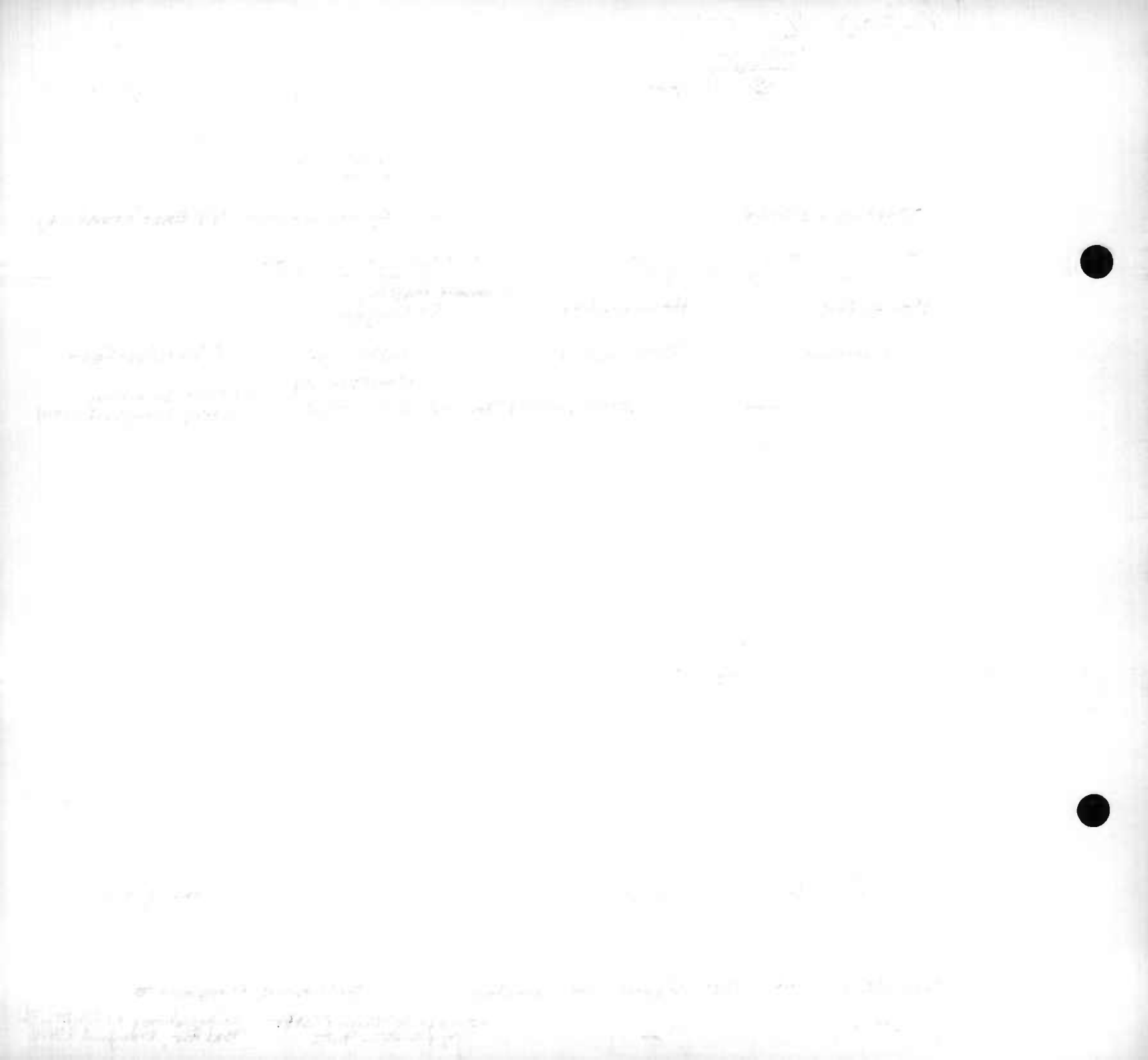
B-326 71 9386		BALTIMORE CITY HEALTH DEPARTMENT		71 9386	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		Bottiger, Henrietta D.		2. DATE AND HOUR OF DEATH 6:45pm 10/5/71 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1307			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Union Memorial Hospital Baltimore 21218, Md		E. STREET AND NUMBER 3901 Beech Ave			
5. SEX F	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 5, 1893	9. AGE (In years last birthday) 78	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10B. KIND OF BUSINESS OR INDUSTRY OWN & Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Bradley H. Davison		14. MOTHER'S MAIDEN NAME Kate Monath		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-07-8754		17. INFORMANT Jack Davison 1301 Burling Rd 21093	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 4319 I Massive cerebral hemorrhage		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/5 1971 to 10/5 1971 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles Forchuck MD		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) C. FAZEKAS MD		23D. ADDRESS U.M.H.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-5-71		24C. NAME of CEMETERY Parkwood Cemetery	
25A. DATE REC'D BY HEALTH DEPT. OCT 12 1971		25B. NAME OF REGISTRAR Baltimore, Md		25C. FUNERAL DIRECTOR Wm. Cook-Beeks Towson, Inc. 1050 York Rd Towson, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

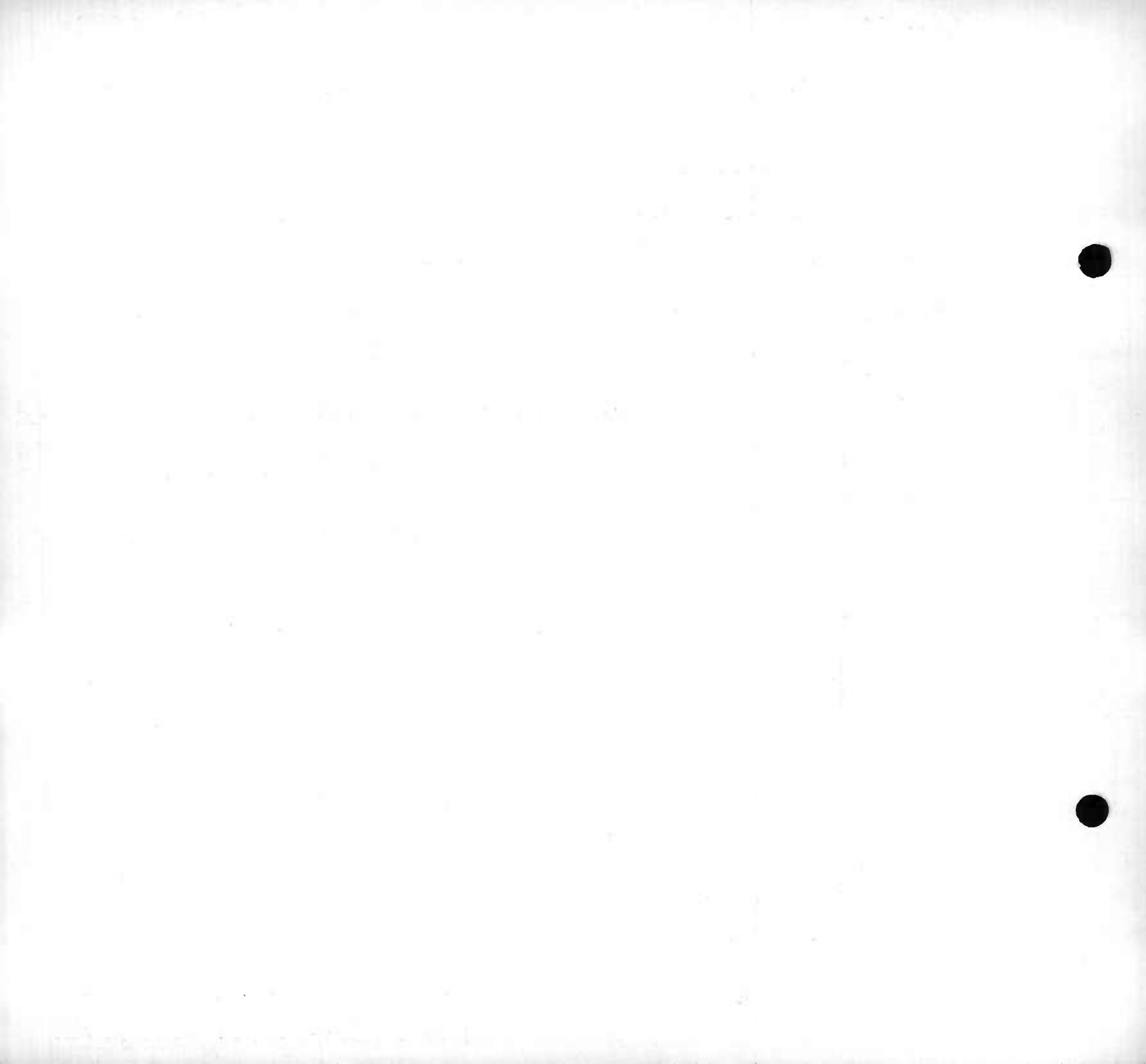
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9387</u>	
1. NAME OF DECEASED (Type or Print) <u>Rose <del>Walburga</del> Matthei</u>		2. DATE AND HOUR OF DEATH <u>10-9-1971</u> <u>9:20 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MONTEBELLO STATE HOSPITAL</u> <u>2201 Argonne Drive</u>		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Harford Co.</u> C. CITY OR TOWN <u>Bel Air</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2201 Argonne Dr. 44 East Broadway</u>			
5. SEX <u>♀</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-13-1881</u>	9. AGE (in years last birthday) <u>90</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Grand Rapids, Michigan</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Andrew Schmucker</u>		14. MOTHER'S MAIDEN NAME <u>Walburga Obendorfer</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>528-74-5371</u>		17. INFORMANT (Son) <u>879-2489</u> ADDRESS <u>44 East Broadway Bel Air, Maryland 21014</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>CARDIAC FAILURE</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CHRONIC BRONCHITIS</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>OSTEOPOROSIS</u> (C) DUE TO, OR AS A CONSEQUENCE OF: <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-17</u> 19 <u>71</u> to <u>10-9</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10-9</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. E. Cabanela MD</u>		23B. DATE SIGNED <u>Oct. 9, 1971</u>		23C. PHYSICIAN'S NAME (Type) <u>M. E. CABANELA</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24B. DATE <u>Oct. 11, 1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. STATE (State) <u>MD</u>		24F. ADDRESS <u>6817 B Townbrook Dr Balto 21207</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway &amp; Williams St Bel Air, Maryland 21014</u>	



# FUNERAL DIRECTOR: IMPORTANT

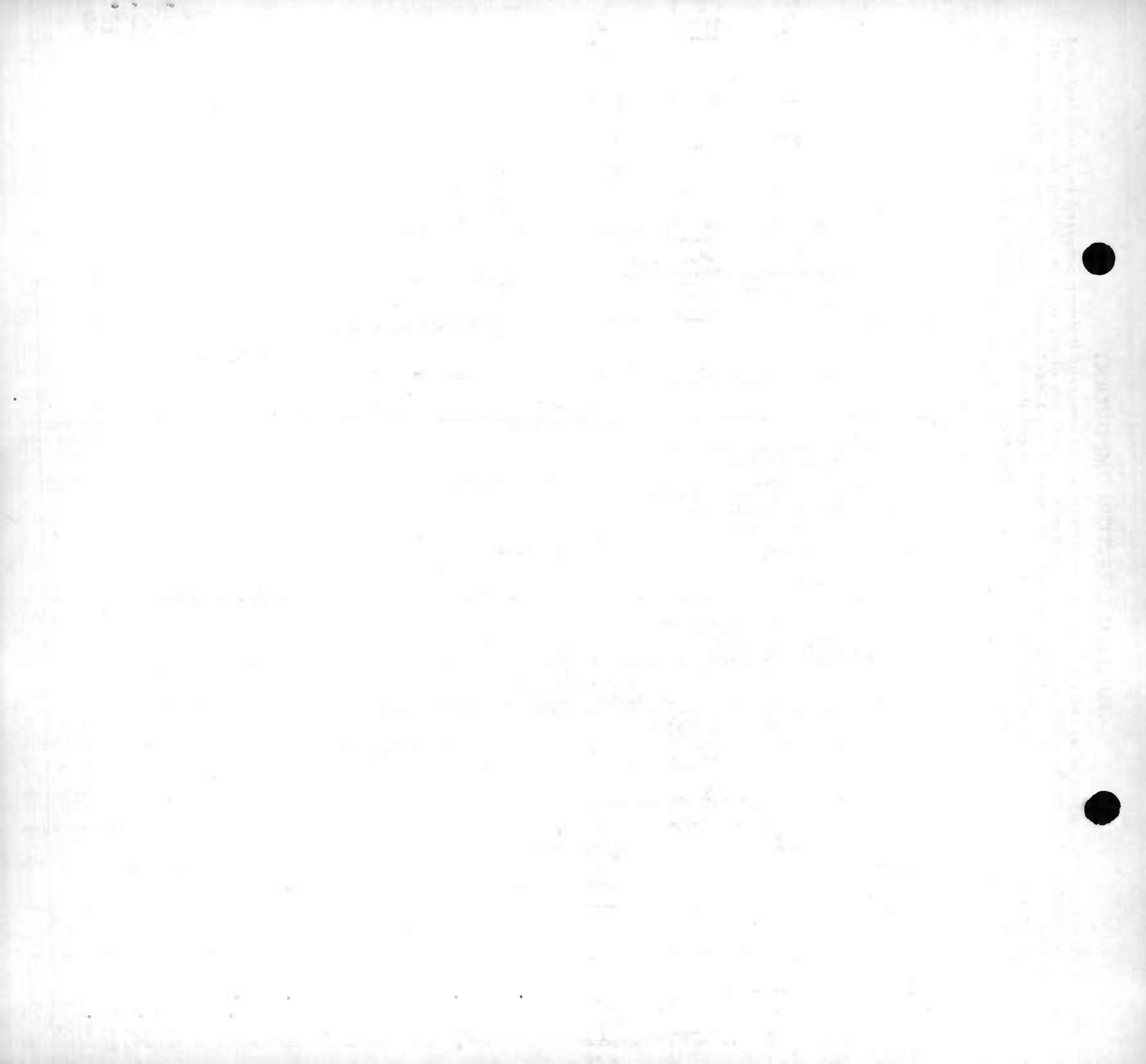
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-526 71 9388		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9388	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MANGER, HERBERT A.		2. DATE AND HOUR OF DEATH 10-5-71 8:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		5. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital 900 Caton Avenue Baltimore, Maryland 21229		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 1206 Locust Avenue	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-16-03	9. AGE (In years last birthday) 67	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10B. KIND OF BUSINESS OR INDUSTRY Electric		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George M. Manger		14. MOTHER'S MAIDEN NAME Mary E. Rieny	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-03-8986		17. INFORMANT Thelma L. Manger 1206 Locust Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 451.01 Pulmonary Embolism		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Phlebitis Leg.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Coronary artery dis		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 1971 to Oct 5 1971 that (I) (we) lost saw the deceased alive on 9/21 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Earl Pass MD		23B. DATE SIGNED 10/5/71		23C. PHYSICIAN'S NAME (Type) Dr. Earl Pass, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/8/71		24C. NAME OF CEMETERY OR CREMATORY London Park Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Ambrose, Inc. 1328 Sulphur Sp. Rd.	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

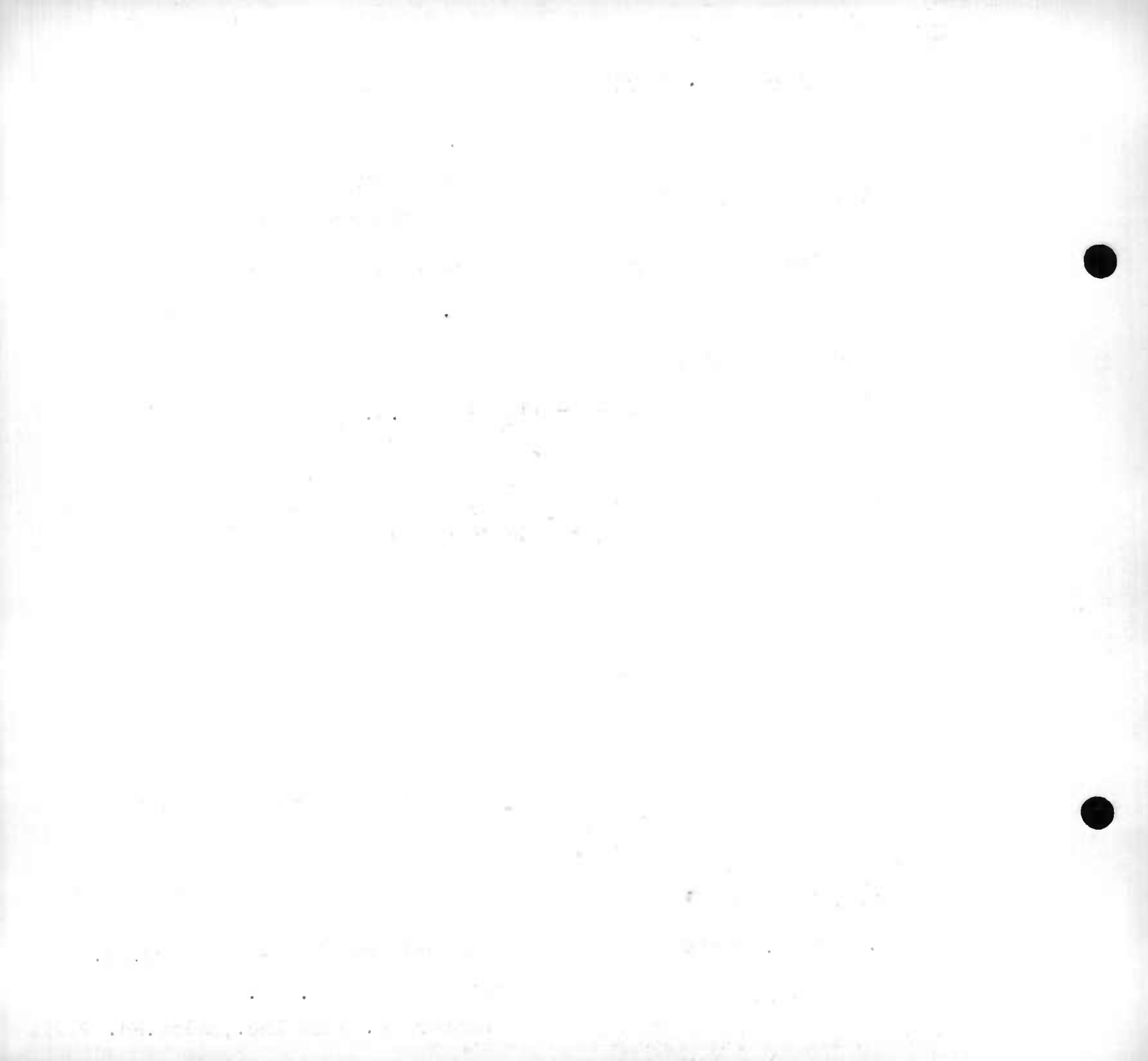
K-236 71 9389		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9389	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) KACHADOURIAN, ARMENOOHI		2. DATE AND HOUR OF DEATH Oct 7, 1971 12.45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION union Memorial Hospital 44		A. STATE MD		B. COUNTY Baltimore city 1307	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3838 Roland Ave.			
5. SEX Female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-21-1890	9. AGE (in years last birthday) 81	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Armenia	
12. CITIZEN OF WHAT COUNTRY? USA American		13. FATHER'S NAME Demirjian		14. MOTHER'S MAIDEN NAME Anna Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-20-7967		17. INFORMANT A Ara N Kachadourian 1309 E Northern Prkwy.	
18. 437.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia (B) Rt. hemiplegia = Aphasia (C) Arteriosclerotic cerebrovascular disease II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Hypertension, (B) hemiplegia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 3 days. 20 yrs. 8 yrs & 2 mths resp	
MEDICAL CERTIFICATION		19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) no	
21D. TIME OF INJURY (Approx.) no		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? no injury	
22. I certify that (I) (this hospital) attended the deceased from 10/5/71 to 10/7/71 that (I) (we) last saw the deceased alive on 10/7/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE S. Desai M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) S. J. DESAI M.D.		23D. ADDRESS union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-9-71		24C. NAME OF CEMETERY OR CREMATORY Moreland Mem. Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 12 1971			
25B. NAME OF REGISTRAR Phyllis J. Kelly		25C. FUNERAL DIRECTOR Ruck Inc. Balto. Md. 21214 5305 Harford Rd. B.S.			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-165 71 9390				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 9390	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>Katherine E. Evering</b>		2. DATE AND HOUR OF DEATH <b>October 7, 1971 7:40 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 EDGEWOOD NURSING HOME</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>337 Homeland Southway</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/15/1880</b>		9. AGE (In years last birthday) <b>91</b>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Conrad Siepelmyer</b>				14. MOTHER'S MAIDEN NAME <b>Katherine E Dippolsman</b>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-48-6117</b>		17. INFORMANT <b>J1 Mr B.E. Evering same</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>199.0 I Cardio Respiratory Failure</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Metastatic Carcinoma 3 years</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Metastatic Carcinoma 3 years</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>January 1968</b> to <b>Death</b> 19 <b>1971</b> that (I) (we) last saw the deceased alive on <b>10/6/71</b> 19 <b>1971</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>John R. Davis</b>				23B. DATE SIGNED <b>10/7/71</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. John R. Davis</b>	
23D. ADDRESS <b>Medical Arts Bldg-Baltimore Md.</b>		23E. DEGREE <b>DEGREE</b>		23F. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/7/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. J. Davis, MD.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc., Balto. Md.</b>		ADDRESS <b>21214</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9391</u>	
S-364 71 9391				CERTIFICATE OF DEATH	
BIRTH NO. <u>1</u>		1. NAME OF DECEASED (Type or Print) <u>PHILLIP L. STERLING</u>		2. DATE AND HOUR OF DEATH <u>10/6/71</u> <u>3:40 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE JOHNS HOPKINS HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1401</u>		
			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>1111 PARK AVE</u>		
5. SEX <u>M</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/28/01</u>	9. AGE (in years last birthday) <u>70</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>PAINTER</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Edwin Strong</u>		
14. MOTHER'S MAIDEN NAME <u>Aurelia Long</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>213 09 4917</u>			17. INFORMANT <u>Mrs Ruth Sterling Same Above</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>410.01</u> <u>CARDIAC ARREST 2° MYOCARDIAL INFARCTION</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~3yrs.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>HASCDV — CHRONIC</u>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>~3yrs.</u>		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>8/19</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>8/19</u> 19 <u>71</u> to <u>10/6/71</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>10/6</u> 19 <u>71</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C. Timothy Golumbeck M.D.</u>				23B. DATE SIGNED <u>10/6/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>C. TIMOTHY GOLUMBECK M.D.</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10 11 71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Hagerstown, Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Balto, Md.</u>			

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Handwritten signature or text, possibly "C. J. ...".

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9392

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9392

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Allan Michael Lubner		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 10 5 71 10:10 P.M.	
4. PLACE IN BALTIMORE, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 712 Cathedral Street		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 5 71 10:10 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Feb 28 1913		10. AGE (In years lost birthday) 58	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk		15. MOTHER'S MAIDEN NAME IDA	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW11		17. SOCIAL SECURITY NO. 212-01-7002	
18. INFORMANT Mr David A. Lubner		ADDRESS 10 Strawhat Rd. Apt. 1-D	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) No	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10 11 71	
24C. NAME OF CEMETERY or CREMATORY Moreland Mem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 12 1971		25B. NAME OF REGISTRAR Leonard J. Ruck	
25C. FUNERAL DIRECTOR ADDRESS		25D. NAME OF REGISTRAR Leonard J. Ruck	

SEP 1

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RECEIVED AT THE OFFICE OF THE SECRETARY OF THE ARMY

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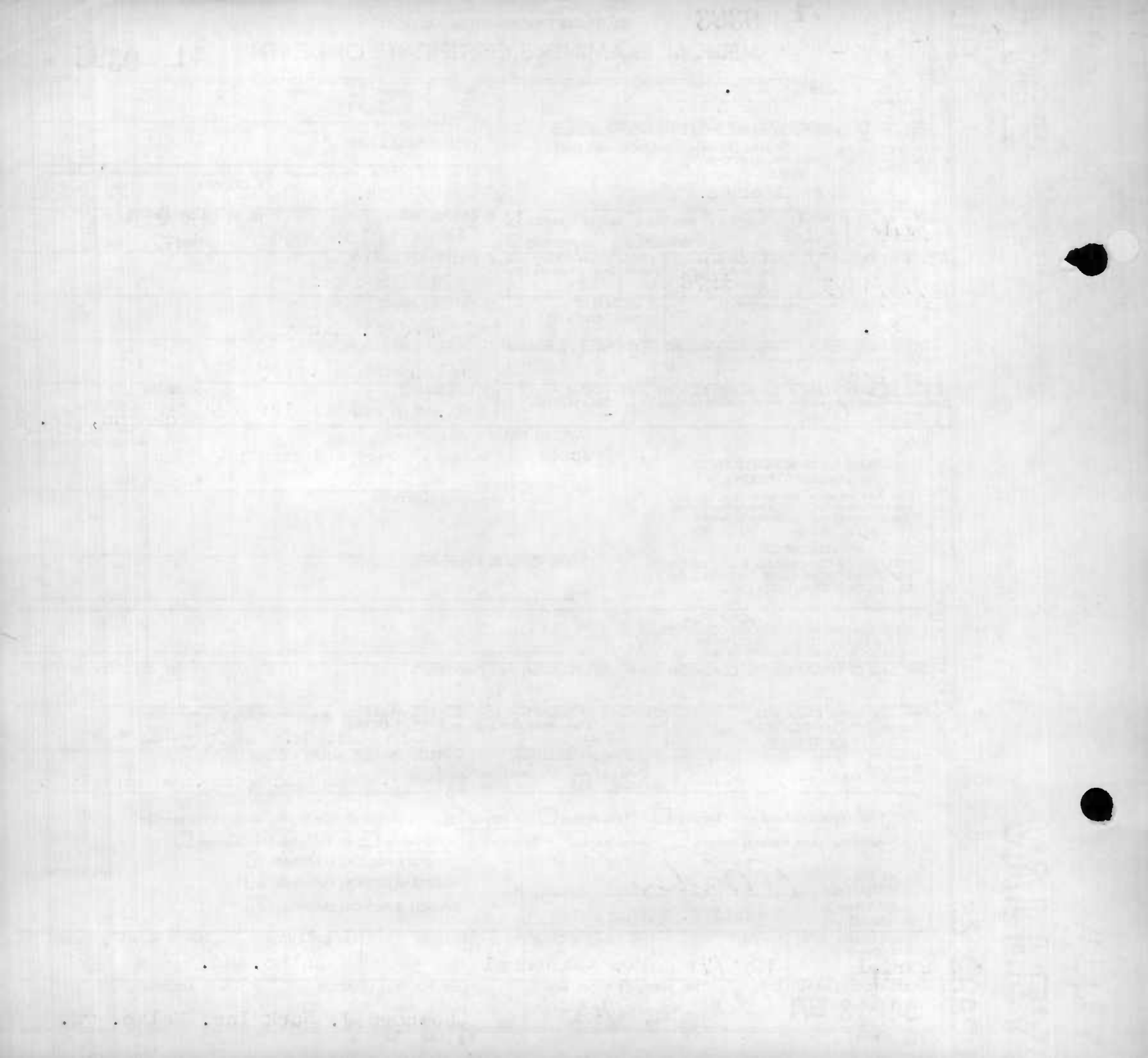
BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9393

BIRTH NO. H-500

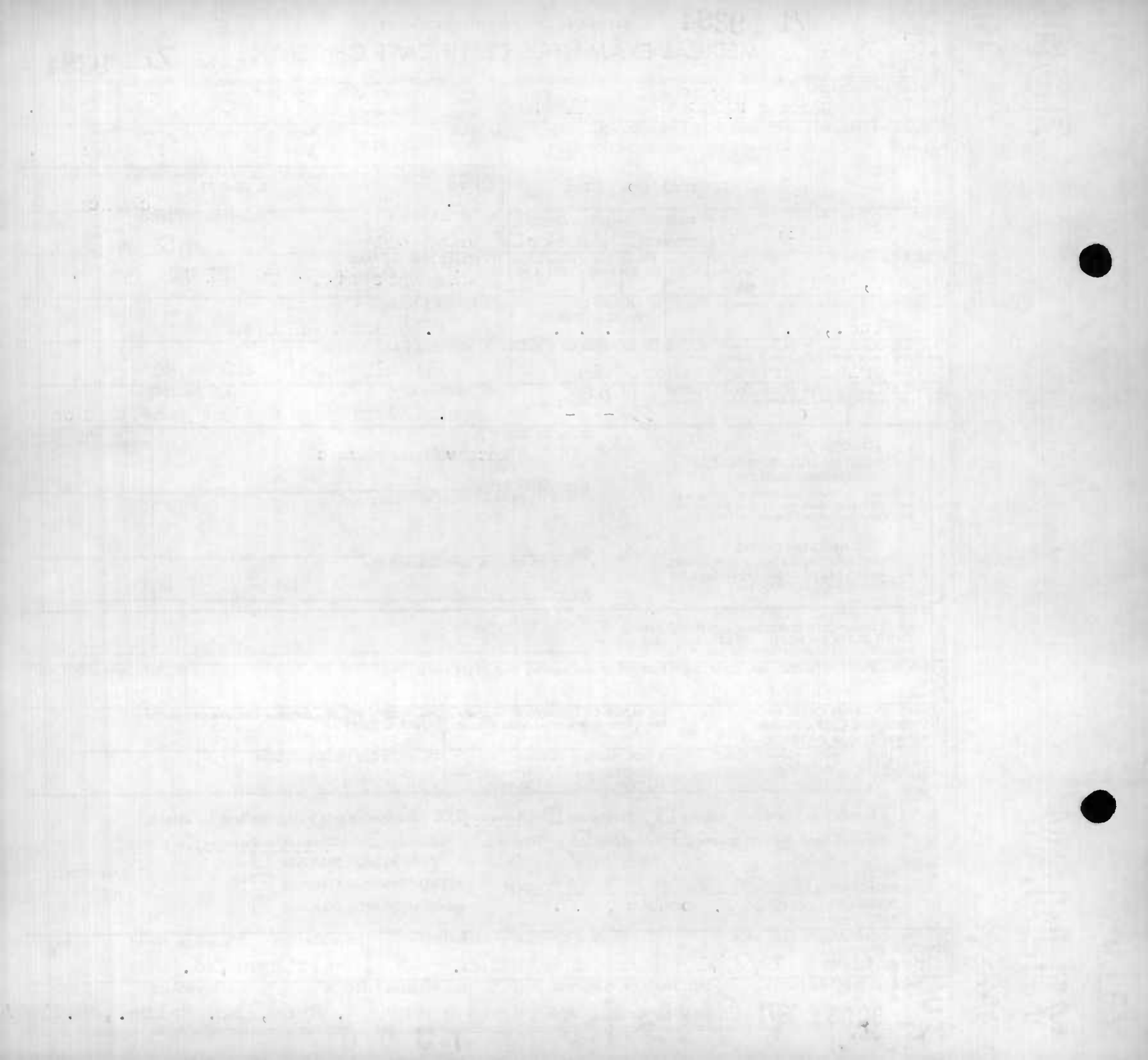
1. NAME OF DECEASED (Type or Print) <b>HELEN HANEY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 938 Wilmot Ct.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 4 1971 11:30a</b> M.	
6. SEX female		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH <b>6/29/1893</b>		10. AGE (In years lost birthday) <b>78</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		15. MOTHER'S MAIDEN NAME Helen Rhoda Corry	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. -	
18. INFORMANT Mrs. teresa Taylor		ADDRESS 705 Windomere Richmond, Va.	
19. <b>E 968 X 1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Fracture of facial bones and cervical spine  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 938 Wilmot Ct. <b>1002</b>		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>10-4-71 11:20 a</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subj. assaulted by unknown assailant.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10-4-71</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE <b>10/9/71</b>	
24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		ADDRESS Balto. Md.	

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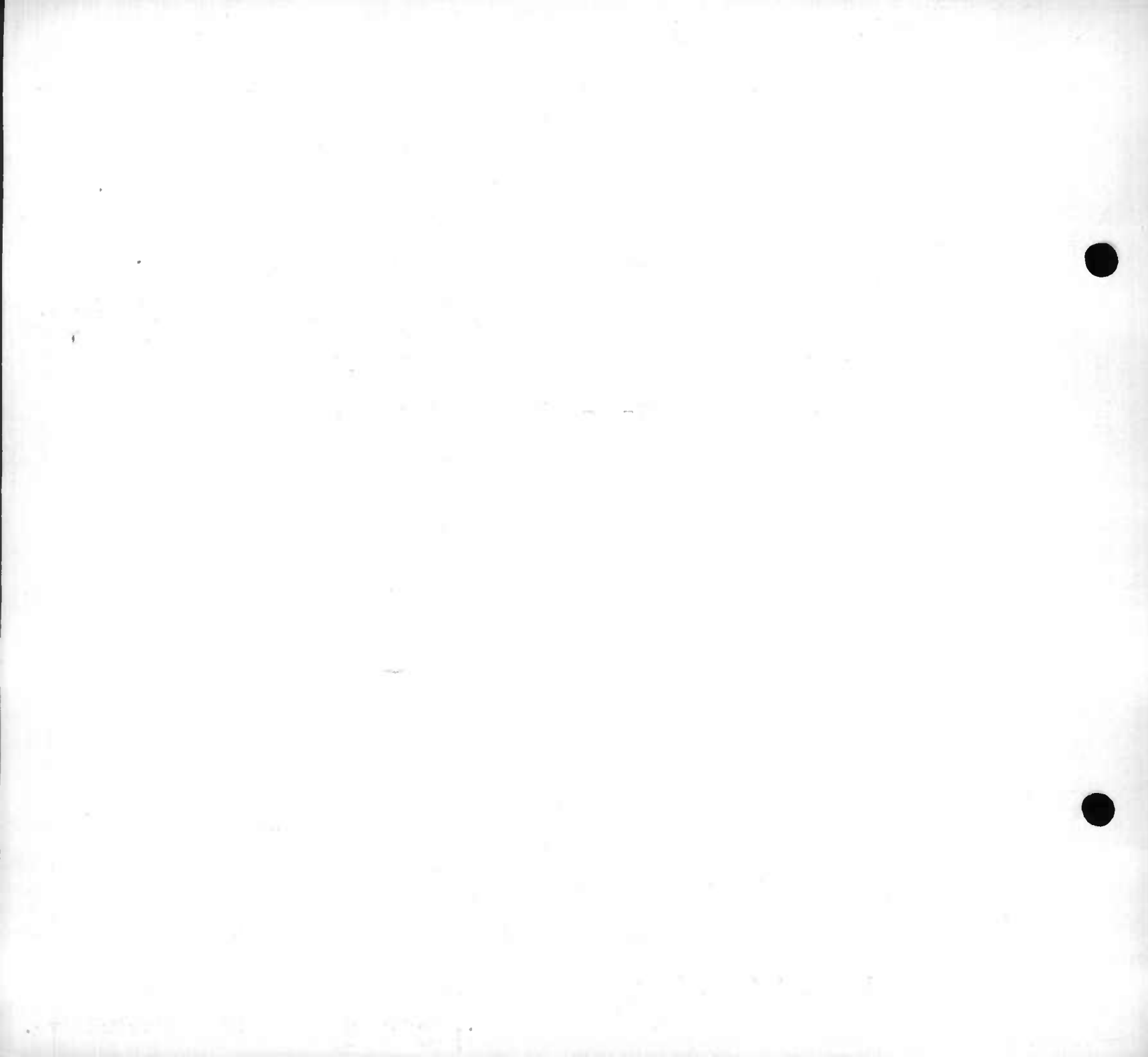


BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 71 9394					
BIRTH NO. W-425-71 9394													
1. NAME OF DECEASED (Type or Print) Barbara Jane Willson						2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 5 Year 71 Hour 10:05 p.m.							
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital						3. DATE PRONOUNCED DEAD Month 10 Day 5 Year 71 Hour 10:05 p.m.							
6. SEX female						7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Wicomico			
9. DATE OF BIRTH June 9, 1951						10. AGE (In years last birthday) 20		11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Federal Bureau of Narcotics						14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME W. Colman Willson					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no						17. SOCIAL SECURITY NO. 552-26-1000		15. MOTHER'S MAIDEN NAME Ella Elizabeth Schleunes					
18. INFORMANT Mrs. Elizabeth DuBell						18. ADDRESS Same as above							
19. 304.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						CAUSE OF DEATH Intravenous narcotism (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 7						20B. CONDITION FOR WHICH OPERATION WAS PERFORMED						21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)						22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23. I certify that I held on inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>  ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED 10/6/71													
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation				24B. DATE 10/8/71		24C. NAME of CEMETERY or CREMATORY Greenmount Cem.				24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. OCT 12 1971				25B. NAME OF REGISTRAR Robert E. Farber, M.D.				25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto., Md. 21214					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 71 9395	
S-152 71 9395		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Sappington M. Louise</u>		2. DATE AND HOUR OF DEATH <u>Oct 5, 1971</u> <u>1:00 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>LUTHERAN HOSPITAL OF MD.</u> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u>		5. CITY OR TOWN <u>Baltimore</u>	
6. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER <u>15 Vista Mobile Drive 21222</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-89</u>	9. AGE (In years last birthday) <u>82</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Davidson Chemical</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Crook Conway</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie G. Adams</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-01-9464</u>		17. INFORMANT <u>CHART</u>	
18. <u>412-41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Arteriosclerotic cardiovascular disease</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>with atrial fibrillation, CHF</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Large hiatal hernia</u>					
19A. DATE OF OPERATION <u>1</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) _____	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/14/71</u> 1971 to <u>10/5/71</u> 1971 that (I) (we) last saw the deceased alive on <u>10/5/71</u> 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Morton M. Krieger MD</u>		23B. DATE SIGNED <u>Oct 5, 1971</u>		23C. PHYSICIAN'S NAME (Type) <u>MORTON M. KRIEGER MD.</u>	
23D. ADDRESS <u>615 HAMMONDS LANE BALTIMORE 21225</u>					
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/8/1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1971</u>			
24F. NAME OF REGISTRAR <u>Robert E. Sabin, R.D.</u>		24G. FUNERAL DIRECTOR <u>G. Truman Schwab</u>		24H. ADDRESS <u>3512 Frederick Ave.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9396</u>	
1. NAME OF DECEASED (Type or Print) <u>William L. Price</u>		2. DATE AND HOUR OF DEATH <u>Oct 2 1971</u> <u>3 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>401</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 MT Sinai Nursing Home</u> <u>4613 Park Heights Ave</u> <u>Balto Md 21215</u>		C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>113 N Poca Street</u>					
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-17-1883</u>	9. AGE (In years last birthday) <u>88</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Emory Price</u>		14. MOTHER'S MAIDEN NAME <u>Ella Wheeler</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-20-6713</u>		17. INFORMANT <u>Mt. Sinai Nursing Home 4613 Park Hgts Ave.</u>	
18. <u>491X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Chronic Brain Syndrome</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>Senility</u> <u>Chr. Bronchitis</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Senility</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Chr. Bronchitis</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/17/71</u> 19 <u>71</u> to <u>10/2</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10/2</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R.S. Hallins M.D.</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>R.S. Hallins</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-12-71</u> <u>XXXXXXXX</u>		24C. NAME OF CEMETERY or CREMATORY <u>Jessops Methodist Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Cockeysville Baltimore Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Galt</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks</u>		25D. ADDRESS <u>Towson, Inc. Towson Md.</u>	

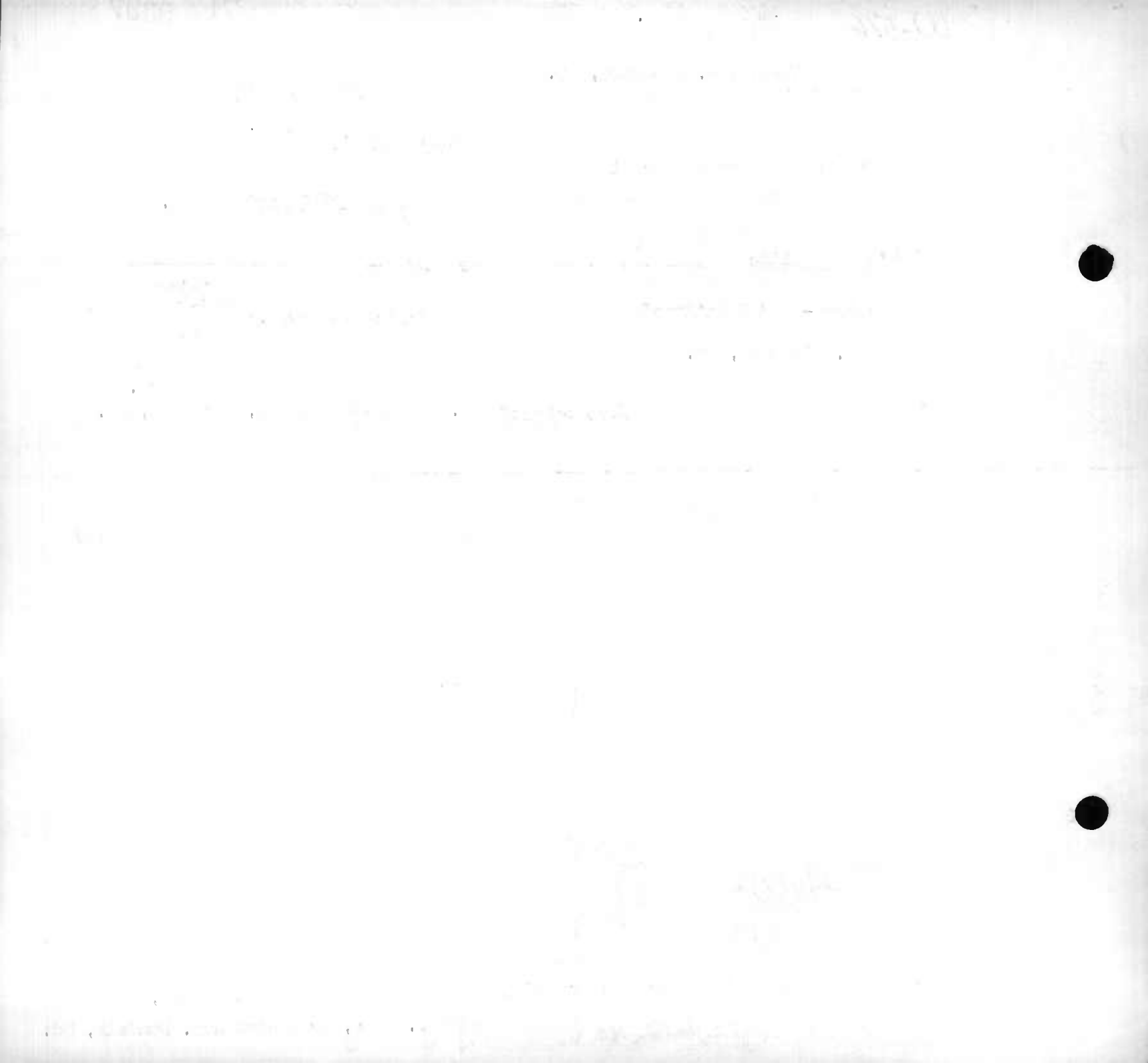
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 9397	
W-516 71 9397				REG. NO.	
BIRTH NO.		1. NAME OF DECEASED <i>CHARLES R. WINEBERG, Jr.</i>		2. DATE AND HOUR OF DEATH <i>10/7/71 10:30 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>NORTH CHARLES GENERAL HOSPITAL</i>		A. STATE <i>MARYLAND</i>		B. COUNTY <i>Baltimore</i>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <i>NORTH CHARLES GEN HOSP.</i>		C. CITY OR TOWN <i>Dundalk</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <i>7310 Martell Ave.</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/29/14</i>	9. AGE (in years last birthday) <i>57</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Yard Master - B &amp; O Railroad</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>PENNSYLVANIA</i>	
13. FATHER'S NAME <i>Charles R. Eineberg, Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Maude Peffer</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216075237</i>		17. INFORMANT (Wife) <i>7310 Martell Ave.</i> <i>Mrs. Margaret Wineberg, Dundalk, Md.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>162.1 I</i>		CAUSE OF DEATH <i>MYOCARDIAL INFARCTION WITH DISSEMINATED COAGULANTS</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>DAY</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:		<i>UNKNOWN</i>	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10/2</i> 19 <i>71</i> to <i>10/7</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>10/7</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>BC Wineberg</i>		23B. DATE SIGNED <i>10/2/71</i>			
23C. PHYSICIAN'S NAME (Type) <i>VERIFICATION</i>		23D. ADDRESS <i>NORTH CHARLES GEN HOSP</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/11/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 12 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. J. J. J.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>John J. Duda, 7922 Wise Ave. Dundalk, Md.</i>	





## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

51-91-39 csk

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 9398	
BIRTH NO. C-164		71 9398		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) CHIVERAL, ALLEN		2. DATE AND HOUR OF DEATH 6/8/71 11:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS		C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4940 Eastern Ave. Baltimore, Md.		E. STREET AND NUMBER 7005 SOLLERS PT. RD. 21222			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/19/06	9. AGE (in years lost birthday) 65	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Chiveral		14. MOTHER'S MAIDEN NAME Beulah Feeney	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 10-3578		17. INFORMANT 4940 Eastern Ave. ADDRESS Baltimore, Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD		3 HOURS	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: ACUTE MYOCARDIAL INFARCT		3 HOURS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 10/8 1971 to 10/8 1971 that (1) (we) last saw the deceased alive on 10/8 1971 and that in my (aur) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael Finn MD		23B. DATE SIGNED 10/8/71		23C. PHYSICIAN'S NAME (Type) FINN, MICHAEL C. MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-12-71		24C. NAME of CEMETERY or CREMATORY Meadowridge Memorial Park	
24D. LOCATION (City, town, or county) Dorsey, Maryland		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR John J. Duda	
24G. FUNERAL DIRECTOR ADDRESS 7922 Wise Ave. Dundalk, Md.		24H. DATE REC'D BY HEALTH DEPT.		24I. NAME OF REGISTRAR John J. Duda	

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## CERTIFICATE OF DEATH

REG. NO. 71 9399

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Collins, Luther J. Sr.

2. DATE AND HOUR OF DEATH

October 8, 1971

4:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

1722 Pinewood Drive

21222

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

8. DATE OF BIRTH

3-3-84

9. AGE (In years  
last birthday)

87

10. Under 1 Yr.  
Months Days11. Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Beth. Steel Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Not Known

14. MOTHER'S MAIDEN NAME

Not Known

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

215-07-61204

17. INFORMANT BCH - Records  
4940 Eastern Avenue

Baltimore, Maryland 21224

ADDRESS

18. 162.1 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

RESPIRATORY ARREST

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

IMMEDIATE

(B)

CARCINOMA OF LUNG

DUE TO, OR AS A CONSEQUENCE OF:

4 MONTHS

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

PNEUMONIA, ASCVD, CHRONIC BRAIN SYNDROME

4 MONTHS

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-14-1971 to 10-8-1971  
that (I) (we) last saw the deceased alive on Oct. 8, 1971 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John J. Chabalko, MD

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

Oct. 10, 1971

23C. PHYSICIAN'S  
NAME (Type)

JOHN J. CHABALKO, M.D.

DEGREE

23D. ADDRESS

BALTO. CITY HOSP. 4940 Eastern Ave.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

10-11-71

24C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

OCT 12 1971

25B. NAME OF REGISTRAR

9710000

25C. FUNERAL DIRECTOR

John J. Duda, 7922 Wise Avenue Dundalk, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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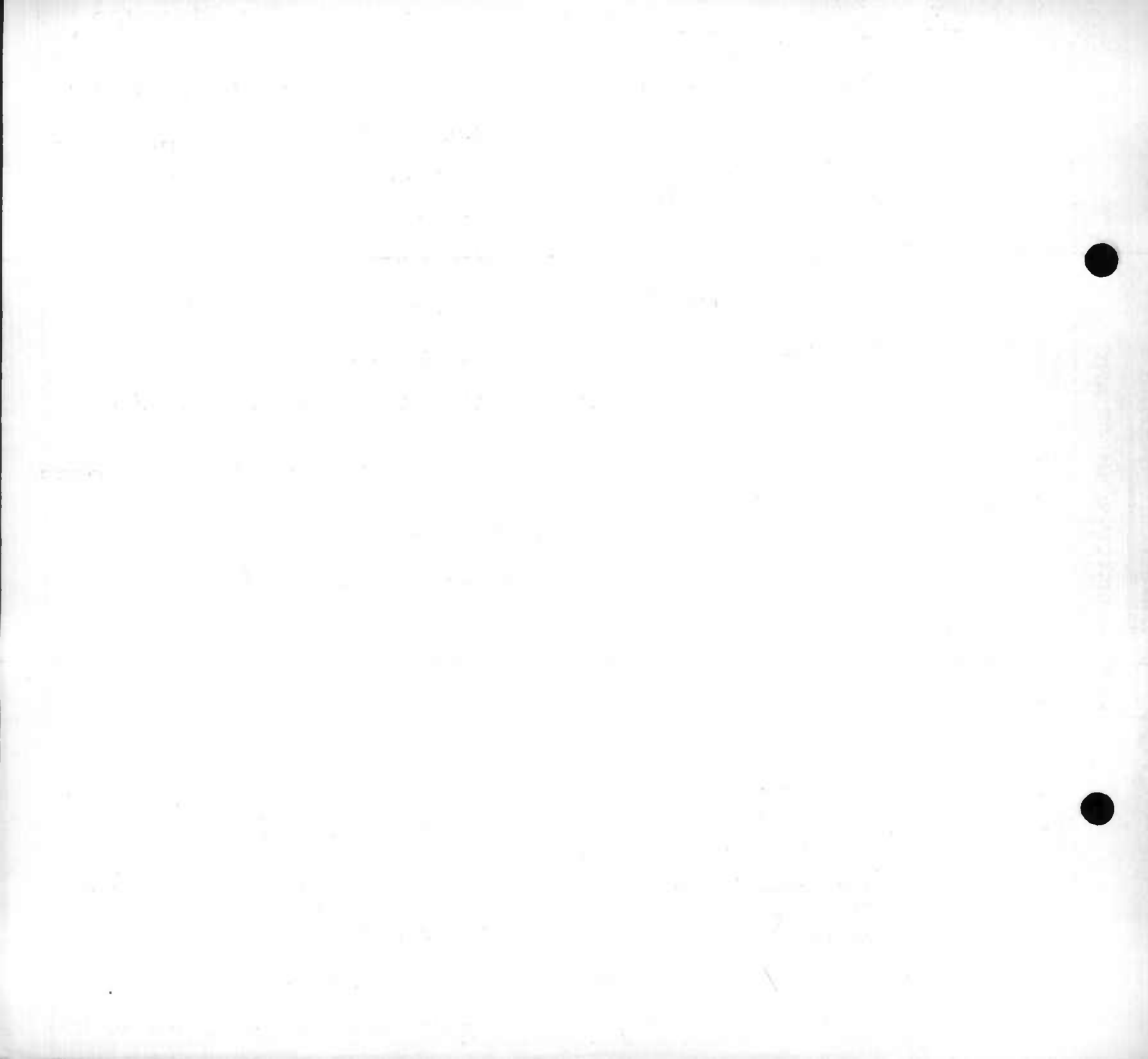
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

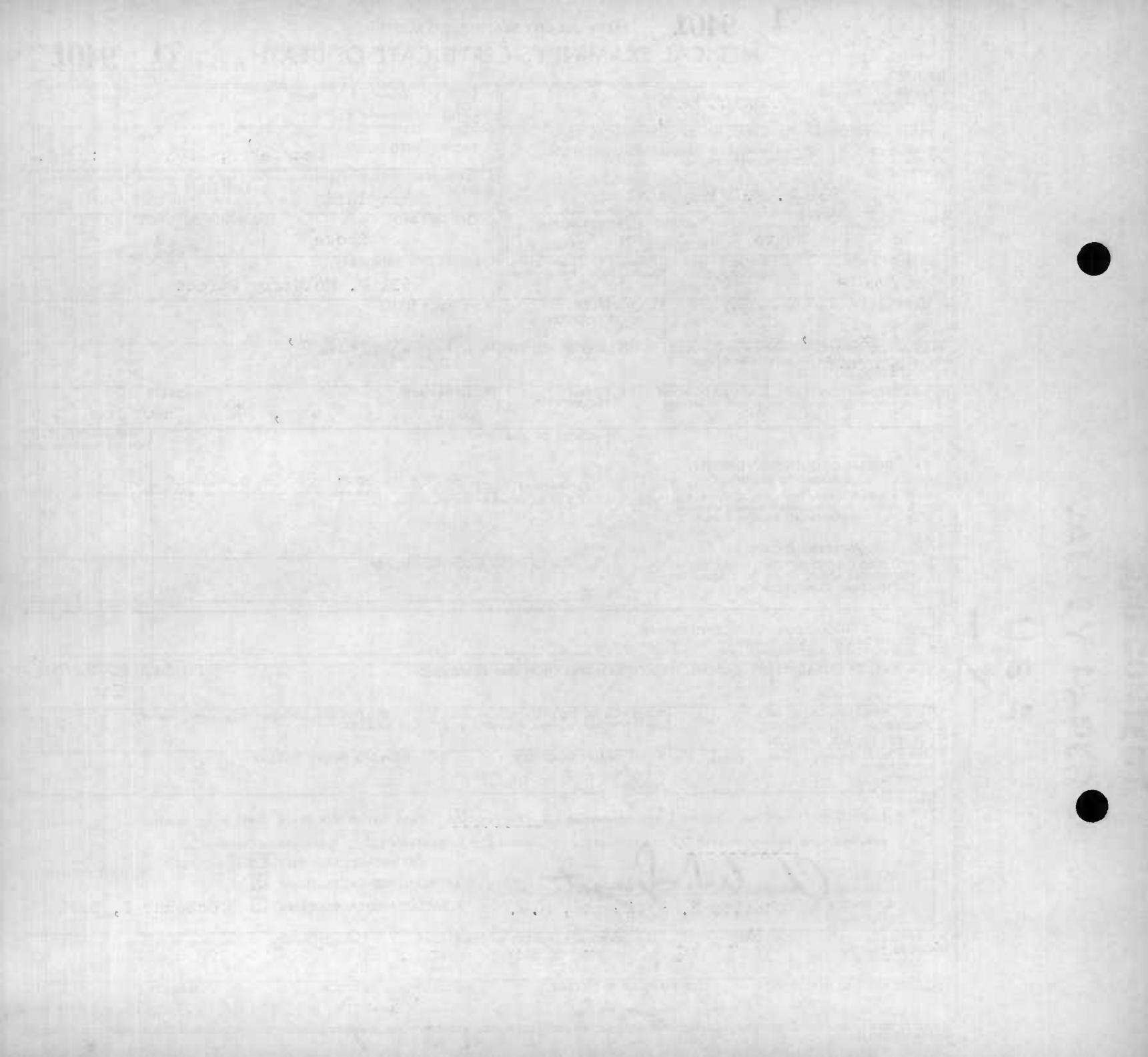
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">71 9400</span>	
7-200 71 9400		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>BESSIE C. FISH</b>		2. DATE AND HOUR OF DEATH <b>10/5/71 12:50 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY HOSPITAL</b> <b>38 BALTIMORE, Md.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2553</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1910 MAISEL ST.</b>			
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/21/14</b>	9. AGE (in years lost birthday) <b>57</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grass Co.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13. FATHER'S NAME <b>Willie Norton</b>		14. MOTHER'S MAIDEN NAME <b>Messie J Wright</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217 20 1716</b>		17. INFORMANT <b>Nile A Fish 1910 Maisel Street Bkto 21220</b>	
18. <b>250.91</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CRABROVASCULAR INSUFFICIENCY</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>HYPERTENSION</b> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <b>DIABETES MELLITUS</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>1</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/3</b> 19 <b>71</b> to <b>10/5</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>10/5</b> 19 <b>71</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature] MD</b>		DEGREE <b>MD</b>		23B. DATE SIGNED <b>10/5/71</b>	
23C. PHYSICIAN'S NAME (Type) <b>JERRY SAMUEL</b>		23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/8 71</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>		24D. LOCATION (City, town, or county) (State) <b>Washington Blvd Donsey Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>McGuffy Funeral Home</b>	
				ADDRESS <b>237 Patapsco Ave 21225</b>	



B-650 71 9401 BALTIMORE CITY HEALTH DEPARTMENT  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 9401

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>RUSSELL BROWN</b> <b>RUSSELL N. BROWN, JR.</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 931 W. Mulberry Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>October 7, 1971 8:15 A.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>9/6/28</b>		10. AGE (In years lost birthday) <b>44</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Russell Brown, Sr</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>	
15. MOTHER'S MAIDEN NAME <b>Victoria</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W W 2</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Mrs Elsie Blake, 1707 W Mosher St</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>571.8 I</b> <b>Fatty metamorphosis of liver</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>October 7, 1971</b> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>10/13/71</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Gettysburg National</b>		24D. LOCATION (City, town, or county) (State) <b>Gettysburg Penn</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W north Av</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT C-636 71 9402 BIRTH NO. 9402 CERTIFICATE OF DEATH				REG. NO. 71 9402	
1. NAME OF DECEASED (Type or Print) <b>MOSES CARTER</b>			2. DATE AND HOUR OF DEATH <b>OCTOBER 7, 1971</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>39 Provident Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>-1501</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>618 Collet St</b>		
5. SEX <b>M</b>	6. RACE <b>B</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/11/88</b>	9. AGE (In years last birthday) <b>88</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>	
13. FATHER'S NAME <b>Charles Carter</b>			14. MOTHER'S MAIDEN NAME <b>Charlotte</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>237-32-6667</b>		17. INFORMANT ADDRESS <b>Mrs Myrtle Carter, Same</b>	
18. <b>150X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CAARCINOMA of the Esophagus</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>March 23</b> 19 <b>71</b> to <b>October 5</b> 19 <b>71</b> and that (2) (we) lost saw the deceased alive on <b>October 5</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.					
23A. SIGNATURE <b>H. C. ALEVIZADOS, MD</b>				23B. DATE SIGNED <b>October 8, 1971</b>	
23C. PHYSICIAN'S NAME (Type) <b>H. C. ALEVIZADOS, MD</b>				23D. ADDRESS <b>1209 St. Paul St. Balto Md 21202</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/12/71</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt Auburn Cemetry</b>	
24D. LOCATION <b>Baltimore, M</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		25D. ADDRESS <b>1206 W North Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

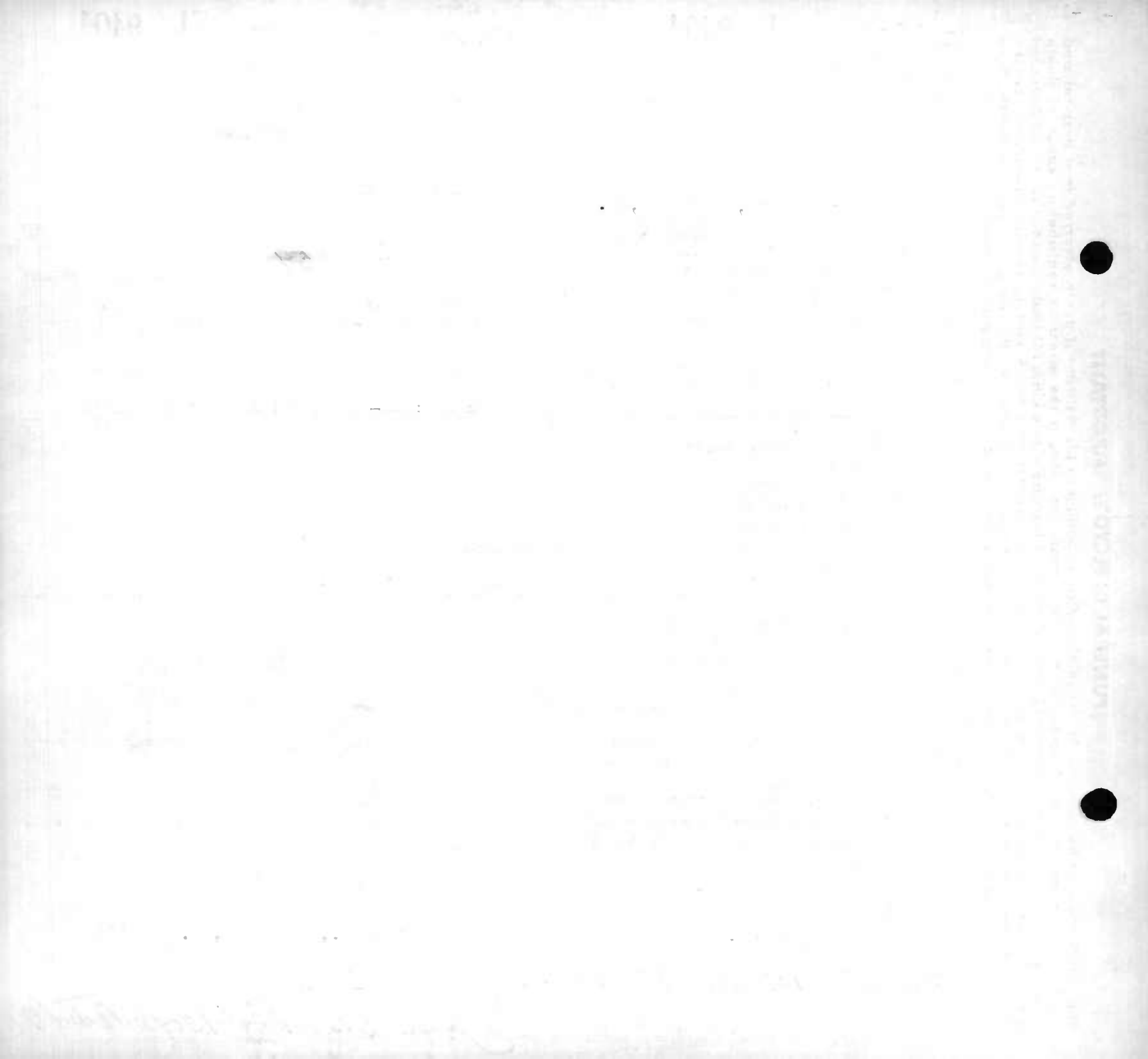
R-300 71 9403		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 9403	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
CORA B Reid		10-7-71			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
005206 Gwynn Oak Ave		MARYLAND BALTO		2802	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
F		W		8. DATE OF BIRTH 11-17-1883	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
AT Home				87	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Cambridge, Md		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
James R. Thomas		Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				James E. Reid - 6737 Windsor Mill Rd.	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		3 years	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1968 April 4 to 10/7/71		that (I) (we) last saw the deceased alive on 3/18/71		and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED			
Sgt. Smith		10/8/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		10-9-71		Cambridge Cemetery	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
Cambridge, Maryland		OCT 12 1971		Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR ADDRESS		25D. NAME OF REGISTRAR		25E. FUNERAL DIRECTOR	
Armanas to Funeral Chapel - 4800 Liberty Ave					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Chester W. Clay</u>		2. DATE AND HOUR OF DEATH <u>10-8-71</u> <u>12<sup>30</sup></u> <u>PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>833</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospital</u> 4940 Eastern Avenue, Baltimore, Md.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>2403 E. Chase St.</u>	
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-12</u>	9. AGE (in years last birthday) <u>59</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Gettysburg, Penn</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Records: BCH-4940 Eastern Avenue 21224</u>	
18. <u>441.01</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pseudomonas Pneumonia</u> (B) <u>Auto-iliac graft surgery</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Dissecting Abdominal aneurysm</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>10-1-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Dissecting Abdominal Aneurysm</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>10-1-71</u> 19 <u>71</u> to <u>10-8</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10-8</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Noble Hansen, Jr.</u>		23B. DATE SIGNED <u>10-8-71</u>		23C. PHYSICIAN'S NAME (Type) <u>Noble Hansen, Jr.</u>	
23D. ADDRESS <u>4940 Eastern Ave., Baltimore, Md. 21224</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/12/71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Balt. Md.</u>		25A. DATE REC'D. BY HEALTH DEPT. <u>Oct 12 1971</u>	
25B. NAME OF REGISTRAR <u>Joseph J. Hollock, Jr.</u>		25C. FUNERAL DIRECTOR <u>1304 N. Central Ave</u>		25D. ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9405</u>	
BIRTH NO. <u>S-561 71 9405</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Samuel Summerville</u>			2. DATE AND HOUR OF DEATH <u>10/10/71 11:30 p.m.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Johns Hopkins Hospital</u> <u>33</u>			A. STATE <u>Md</u> B. COUNTY <u>Balt.</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2438 E. Preston St</u>		
5. SEX <u>male</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/11/02</u>	9. AGE (In years last birthday) <u>69</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			11. BIRTHPLACE (State or foreign country) <u>St. Mary's Co., Mc.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>James R Summerville</u>			14. MOTHER'S MAIDEN NAME <u>Harriet Smoot</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>			16. SOCIAL SECURITY NO. <u>212-22-0393</u>		17. INFORMANT <u>2438 E. Preston St. 21215</u> <u>Mrs. Annie Summerville</u>
18. <u>427.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Subarachnoid bleed</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>E. coli RLL pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Poss. CHF</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>4 days</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>None</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>None</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>None</u>	
22. I certify that <u>the</u> (this hospital) attended the deceased from <u>9/28</u> 19 <u>71</u> to <u>10/10</u> 19 <u>71</u> that <u>we</u> (we) last saw the deceased alive on <u>10/10</u> 19 <u>71</u> and that <u>in</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>we</u> (We) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>W. Michael Tucker M.D.</u>				23B. DATE SIGNED <u>10/10/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>W. Michael Tucker</u>				23D. ADDRESS <u>Box 83 601 N. Broadway Baltimore</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-14-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher M.D.</u>		25C. FUNERAL DIRECTOR <u>1735 Harford Avenue</u> <u>Marshall W. Jones, Jr.</u>	



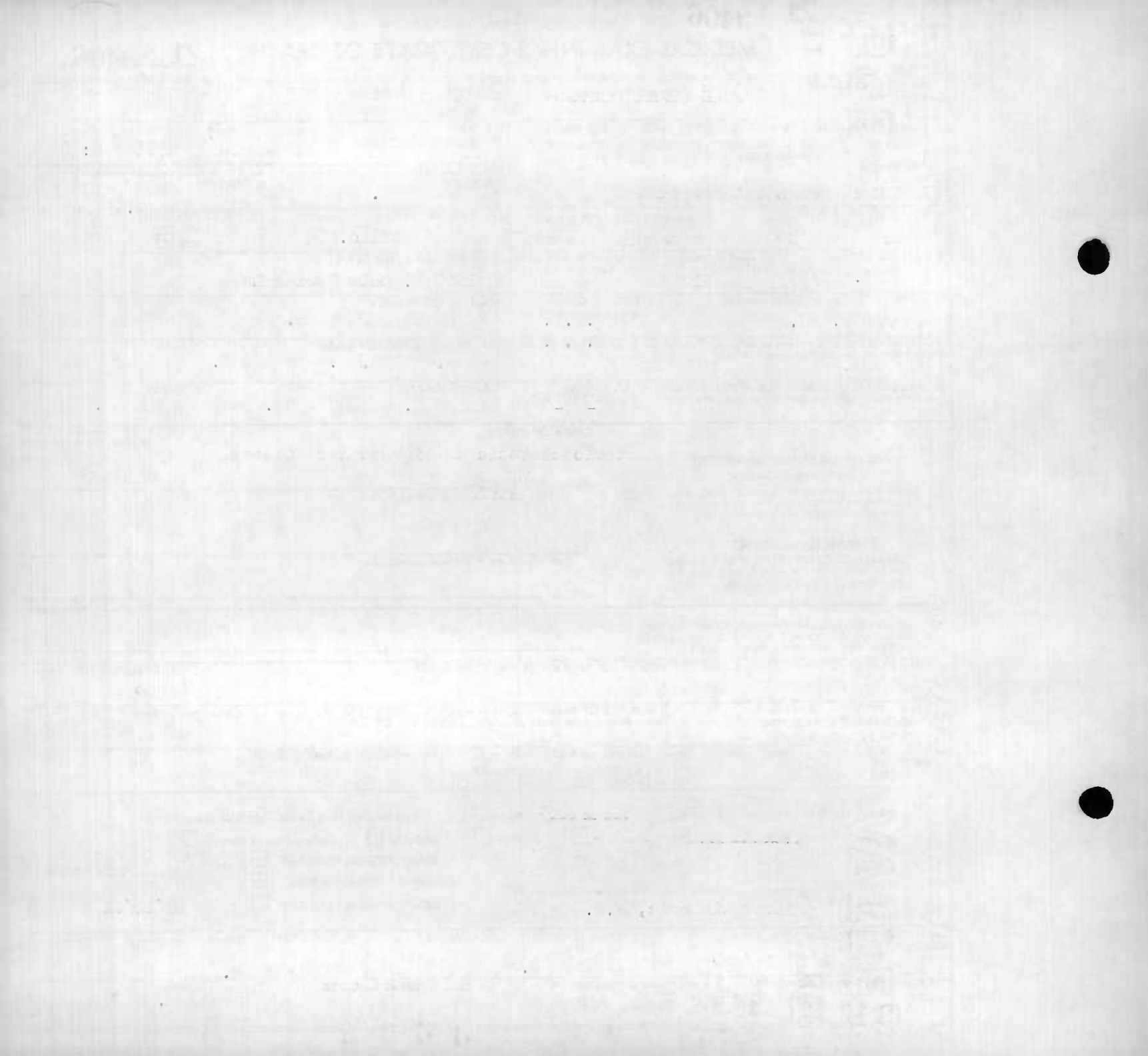


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9406

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN HOWARD MARKS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 10 1971 4:10 p M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH SEPT. 17/71		10. AGE (In years last birthday) 53	
11. BIRTHPLACE (State or foreign country) BALTO. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FERDINAND MARKS.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ADV.	
15. MOTHER'S MAIDEN NAME SUE. SUE. B. NEE DURST.		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 220-01-0935		18. INFORMANT ADDRESS RALPH L. BARTUCCA SR. 1600 INGRAM RD.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) NO			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an inquiry <input type="checkbox"/> inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 10/11/71			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/13/71	
24C. NAME OF CEMETERY or CREMATORY LORRAINE PK.		24D. LOCATION (City, town, or county) (State) WOODLAWN Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 12 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR		25D. ADDRESS 322 S. HIGH	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-655 71 9407		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9407	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>NORMAN, WILLIAM L.</b>			2. DATE AND HOUR OF DEATH <b>October 8, 1971 6:30 P.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>634 Carey St.</b>		
5. SEX <b>Male</b>	6. RACE <b>Negroid</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-18-27</b>	9. AGE (In years last birthday) <b>44</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unk.</b>		11. BIRTHPLACE (State or foreign country) <b>Enfield North Car</b>	
13. FATHER'S NAME <b>Thomas John Norman</b>			14. MOTHER'S MAIDEN NAME <b>Betty Lou Harvey</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 2-8-46 to 3-17-47</b>		16. SOCIAL SECURITY NO. <b>215-22-6898</b>		17. INFORMANT <b>Records V. A. Hospital</b> ADDRESS <b>3900 Loch Raven Blvd., Baltimore, Md. 21218</b>	
18. <b>303.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Cerebral Anoxia</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Anoxia</b> <b>(B) Bronchopneumonia, acute, bilateral, severe</b> <b>(C) Acute and chronic alcoholism</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If only medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 5, 1971</b> to <b>October 8, 1971</b> that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>October 8, 1971</b> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
23A. SIGNATURE <b>Alva A. Baker, M.D.</b>			23B. DATE SIGNED <b>9 Oct 1971</b>		23C. PHYSICIAN'S NAME (Type) <b>ALVA BAKER, M. D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>10-14-71</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>			25B. NAME OF REGISTRAR <b>Robert E. Baker, M.D.</b>		25C. FUNERAL DIRECTOR <b>Robert E. Baker, M.D.</b>
26A. ADDRESS <b>3900 Loch Raven Blvd., Baltimore, Md.</b>			26B. ADDRESS <b>3900 Loch Raven Blvd., Baltimore, Md.</b>		



1		M-200 <sup>71</sup> 9408		BALTIMORE CITY HEALTH DEPARTMENT		71 9408	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>EARLY EARL MC COY</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour		October 6, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital (DOA)</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour		October 6, 1971 8:50 P. M.	
6. SEX <b>Male</b>				7. RACE <b>Negro</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>3/13/1899</b>				10. AGE (In years last birthday) <b>72</b>		11. BIRTHPLACE (State or foreign country) <b>Fairburn, Ga.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>FRANK McCOY</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>	
15. MOTHER'S MAIDEN NAME <b>MARY ELIZA McCOY</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 10/7/18-10/9/19</b>		17. SOCIAL SECURITY NO. <b>217073061A</b>	
18. INFORMANT <b>Mrs. Silpher McCoy</b>				19. ADDRESS <b>Same</b>		20. CAUSE OF DEATH <b>Multiple injuries</b>	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
24. DATE OF OPERATION <b>2</b>				25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No) <b>Yes</b>	
27. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Howard Park &amp; Liberty Heights Ave. 401</b>	
30. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>10-6-71 8:30 P. m.</b>				31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		32. HOW DID INJURY OCCUR? <b>Pedestrian struck by Police car</b>	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <b>October 7, 1971</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>10/11/71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Garden of Eternal Hope Finksburg, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT FUNERAL HOME</b>	
				25D. ADDRESS <b>1701-31 Laurens St., Balto., M</b>			

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EXHIBIT

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EXHIBIT

RECEIVED

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-630 71 9409				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9409	
1. NAME OF DECEASED (Type or Print) <b>MARTHA 4X BYRD</b>				2. DATE AND HOUR OF DEATH <b>10/8/71 6:05 PM.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSPITAL 48</b>				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>A.A.</b> C. CITY OR TOWN <b>JESSUP</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>8680 PINE RD.</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-17-02</b>		9. AGE (In years last birthday) <b>69</b>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Weldon, North Carolina</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13. FATHER'S NAME <b>Kane Clanton</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No No</b>		
16. SOCIAL SECURITY NO. <b>219-03-7742</b>			17. INFORMANT <b>Fred 2x Byrd - 8680 Pine Rd Jessup Md</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>CAOZAC ARREST</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CHF</b> <b>ASCVD</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10-9-22 1971</b> to <b>10-8 1971</b> that (I) (we) last saw the deceased alive on <b>10-8 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Michael Grasso M.D.</b>				23B. DATE SIGNED <b>10/8/71</b>		23C. PHYSICIAN'S NAME (Type) <b>Michael Grasso M.D.</b>	
23D. ADDRESS <b>Maryland General Hosp.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					
24B. DATE <b>10-12-71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) <b>Baltimore, Md</b>		24E. (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>Robert J. J. J.</b>		25C. FUNERAL DIRECTOR <b>4405</b>		ADDRESS	

ST 3103

ST 3103

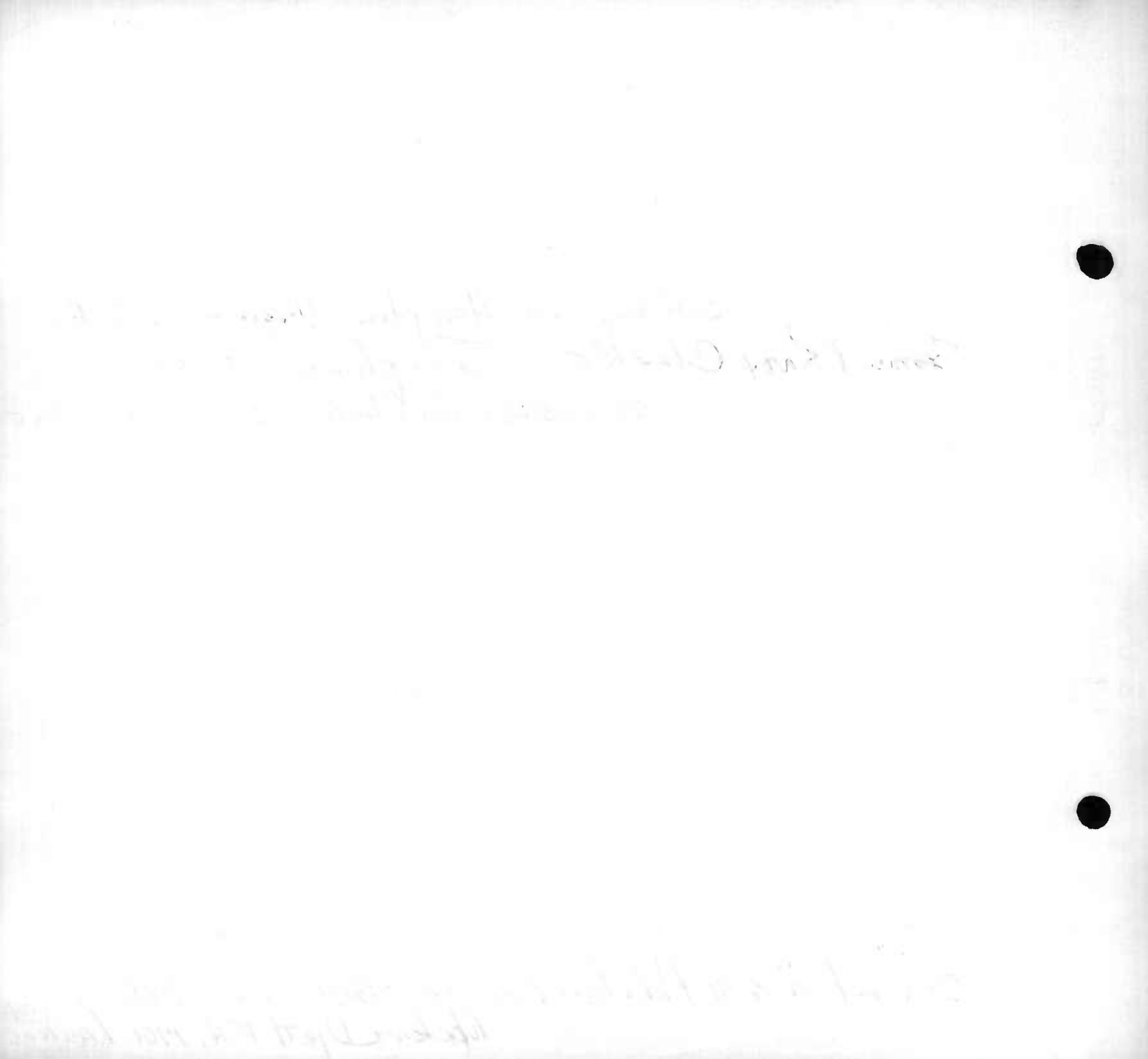
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# FUNERAL DIRECTOR: IMPORTANT

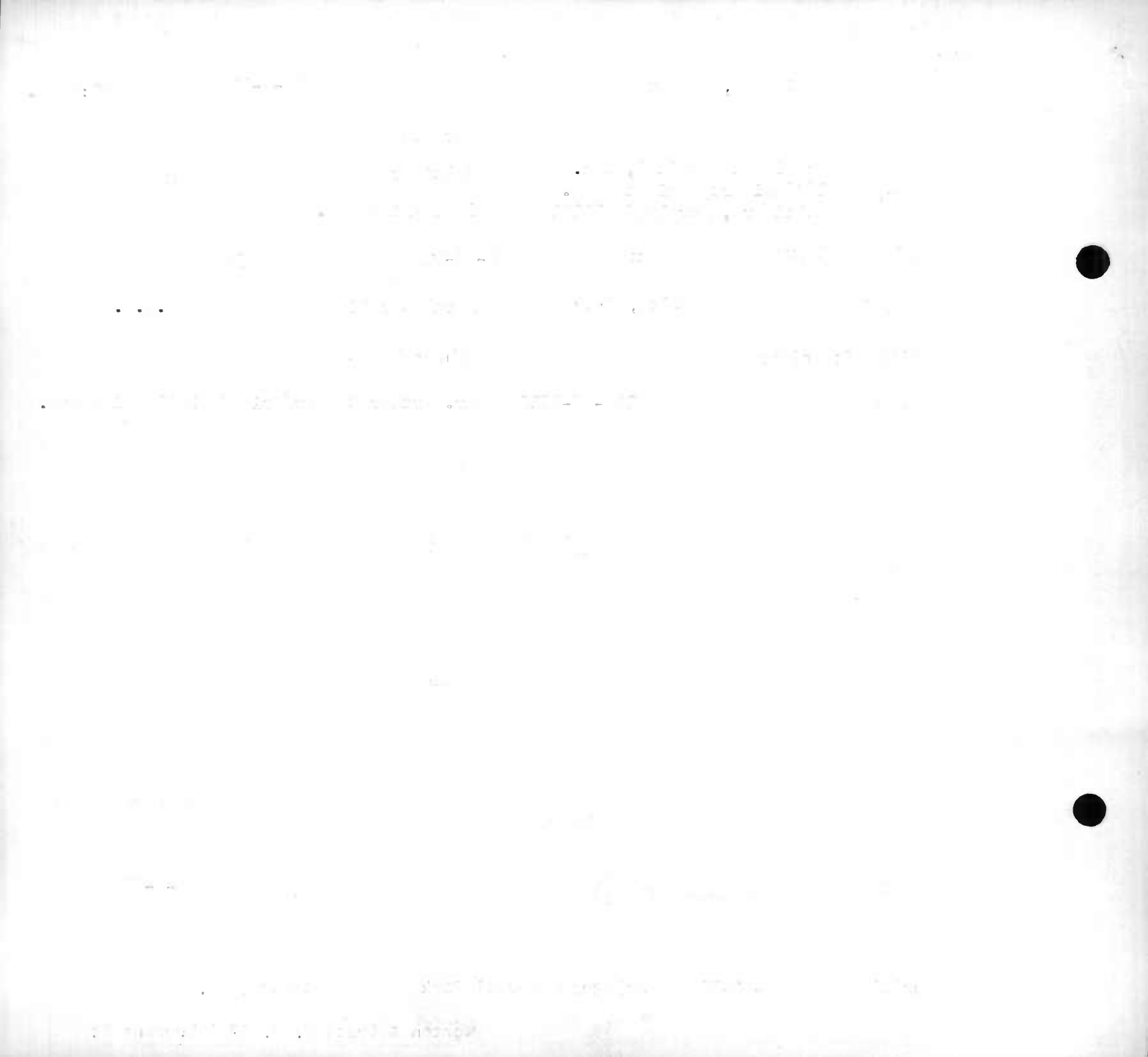
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9410</u>	
C-462 71 9410				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>William Clarke</u>		2. DATE AND HOUR OF DEATH <u>October 8, 1971 12:45 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		M. <u>1403</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u>		A. STATE <u>Maryland</u>		B. COUNTY <u>Baltimore</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>male</u>		6. RACE <u>black</u>		E. STREET AND NUMBER <u>530 Sanford Pl.</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/2/06</u>		9. AGE (in years last birthday) <u>65</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Hampton, Virginia</u>	
13. FATHER'S NAME <u>Samuel Kary Clarke</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Clarke</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-343062</u>		17. INFORMANT <u>Viola Clarke</u>	
				ADDRESS <u>-530 Sanford Place</u>	
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiovascular accident</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/3/71</u> 19 <u>71</u> to <u>10/8</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10/8/1</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Anyana Doshi</u>				23B. DATE SIGNED <u>10/8/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>ANJANA DOSHI</u>		23D. ADDRESS <u>M.D. Lutheran Hospital of Maryland.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-12-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Hebatus Mem Pk.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Michael Dye</u>			
25D. ADDRESS <u>1701-1701-1701</u>		25E. ADDRESS <u>1701-1701-1701</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

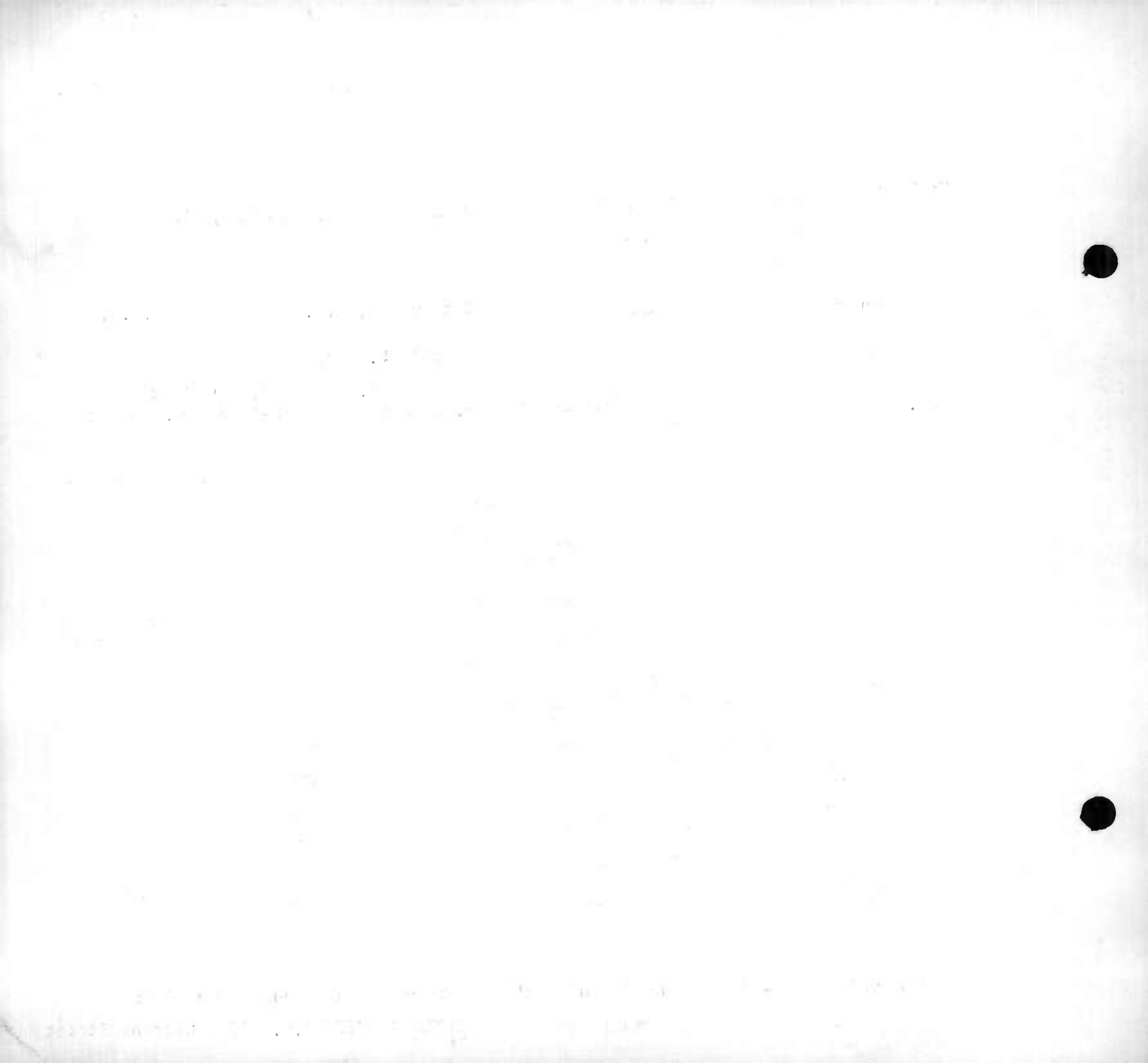
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 9411	
C-160 71 9411				CERTIFICATE OF DEATH	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) COOPER, Roger				10-8-71 12:00 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital, Inc. 2600 Li erty Heights Ave. Baltimore, Maryland 21212				A. STATE Maryland	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3911 Maine Ave.	
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-13	9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY Balto, City		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ellis Etheridge			
14. MOTHER'S MAIDEN NAME Cindy Cooper				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 219-05-7723				17. INFORMANT ADDRESS Mr. Arthur Cooper/Friend 3911 Maine Ave.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4123 I Cerebral Vase Accident					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(B) Other degenerative Heart Disease					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 14 1971 to October 8 1971 that (I) (we) last saw the deceased alive on Oct 8 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. Vanosin M.D.				23B. DATE SIGNED 10-8-71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-12-71		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 12 1971			
25B. NAME OF REGISTRAR Robert E. Smith		25C. FUNERAL DIRECTOR Morton & Dyett F. H.			
25D. ADDRESS 1701 Laurens St					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>71 9412</b>	
BIRTH NO. <b>S-530</b>		71 9412	
1. NAME OF DECEASED (Type or Print) <b>SMITH, Ethel</b>		2. DATE AND HOUR OF DEATH <b>10/11/71 5:56 a.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>New York</b> B. COUNTY <b>Queens</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 The Johns Hopkins Hospital</b>		C. CITY OR TOWN <b>New York</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>32-22 103rd. Street, E. Elmhurst</b>		5. SEX <b>Female</b> 6. RACE <b>Negro</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>8/21/13</b> 9. AGE (In years last birthday) <b>58</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Statesville, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Luther Spann</b>		14. MOTHER'S MAIDEN NAME <b>Carrie L. Sales</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>094-14-2181</b>	
17. INFORMANT <b>E. Elmhurst, New York</b>		ADDRESS <b>Mr. Herman Smith 32-22 103rd. Street</b>	
18. <b>430.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Subarachnoid hemorrhage</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertension</b>		DUE TO, OR AS A CONSEQUENCE OF: <b>8 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Pneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs</b>	
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>None</b>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>None</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>N/A</b>		21F. HOW DID INJURY OCCUR? <b>N/A</b>	
22. I certify that (this hospital) attended the deceased from <b>1 Oct</b> 19 <b>71</b> to <b>11 Oct</b> 19 <b>71</b> that (we) last saw the deceased alive on <b>11 Oct</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Daniel L. Roper</b>		23B. DATE SIGNED <b>11 Oct 71</b>	
23C. PHYSICIAN'S NAME (Type) <b>Daniel L. Roper</b>		23D. ADDRESS <b>Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>10-14-71</b>	
24C. NAME of CEMETERY or CREMATORY <b>Long Island Nat'l Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Pine Lawn, New York</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT</b>		ADDRESS <b>F.H. 1701 Laurens Street</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>CLYDE Z. WALTER</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>October 6, 1971</b> Hour <b>6:00 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>October 6, 1971 6:00 A.M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2664</b>			
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>July 23, 1912</b>	10. AGE (In years lost birthday) <b>59</b>	If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER <b>124 North Janey Street # 21224.</b>
11. BIRTHPLACE (State or foreign country) <b>Dauphin Co., Pa.</b>		12. CITIZEN OF <b>U.S.A.</b>	
13. FATHER'S NAME <b>Zar Walter</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>	
15. MOTHER'S MAIDEN NAME <b>Bertha V. Fendly</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W.II</b>	
17. SOCIAL SECURITY NO. <b>212-12-5305</b>		18. INFORMANT <b>Darlene R. Bennett : 3346 E. Baltimore St.</b>	
19. CAUSE OF DEATH <b>E82610</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute bronchopneumonia</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Subdural hematoma</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Arteriosclerotic cardiovascular disease</b>		(C) _____	
20A. DATE OF OPERATION <b>2</b>	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Janey Street near Fairmount Ave.</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>8-9-71 9:40 P.m.</b>	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	22F. HOW DID INJURY OCCUR? <b>Pedestrian struck by bicycle</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>October 7, 1971</b>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-9-71.</b>	24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>7225 Eastern Blvd., Ba.Co., Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR <b>Charles S. Springate</b> ADDRESS <b>901 S. Conkling St. Balto., 21224, Md.</b>	

Letter from M.E.'s office 11-11-71 M.H.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

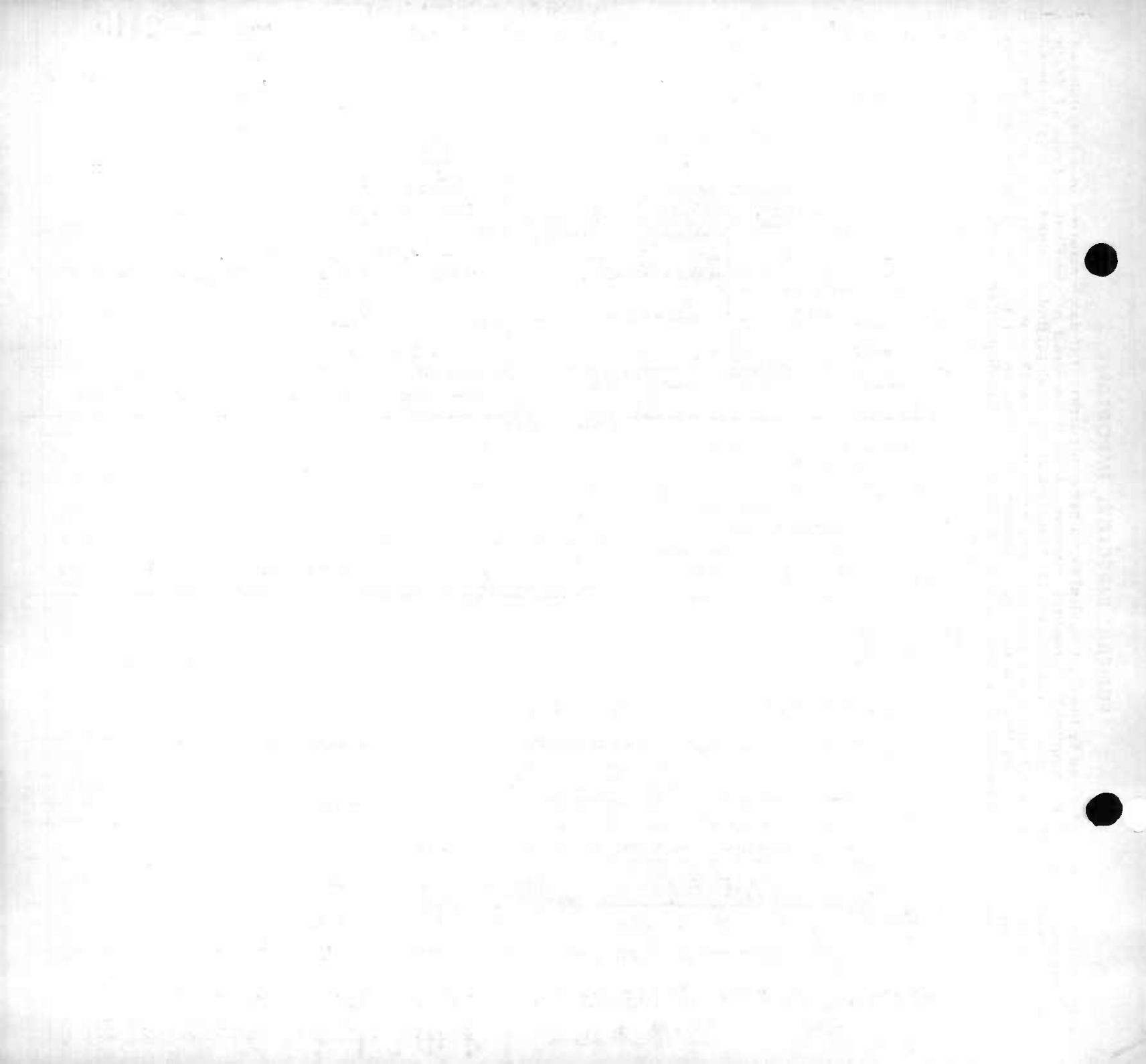
X-510 71 9414		BALTIMORE CITY HEALTH DEPARTMENT		71 9414	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>KNAPP, EDNA, M.</b>			2. DATE AND HOUR OF DEATH <b>10-10-71 9:20 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MONTEBELLO STATE HOSP.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> #21224, 2611 B. COUNTY C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>516 S. Clinton St., #21224.</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-8-08</b>	9. AGE (in years last birthday) <b>63</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>JULIUS GLESMER</b>		
14. MOTHER'S MAIDEN NAME <b>LOUISE WETZELL</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>PHILIP C. KNAPP 516 S. CLINTON ST. 21224, MD.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>GLIOBLASTOMA, Left</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Parietal Lobe of Brain</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>10-10-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6-17</b> 19 <b>71</b> to <b>10-10</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>10-10</b> 19 <b>71</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Renan J. Dureza</b>			23B. DATE SIGNED <b>10-10-71</b>		23C. PHYSICIAN'S NAME (Type) <b>RENAN J. DUREZA</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24B. DATE <b>10-13-71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEM.</b>
24D. LOCATION (City, town, or county) (State) <b>7401 GERMAN HILL RD., BA. CO., MD.</b>			25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		
25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>			25C. FUNERAL DIRECTOR <b>Charles S. Seiler</b>		
25D. ADDRESS <b>901 S. CONKLING ST. BALTO., MD.</b>			25E. ADDRESS <b>901 S. CONKLING ST. BALTO., MD.</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>47-40-83 1b</span> <span>L-20071 9415</span> </div>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>71 9415</b>	
1. NAME OF DECEASED (Type or Print) <b>LEWIS, ANNIE L.</b>			2. DATE AND HOUR OF DEATH <b>October 11, 1971 2:00 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 BALTIMORE CITY HOSPITALS</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>			4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Essex Md.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1434 Goodwood Avenue 21221</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-8-1902</b>	9. AGE (In years last birthday) <b>68 yrs.</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
13. FATHER'S NAME <b>Lee A. Gill</b>		14. MOTHER'S MAIDEN NAME <b>Louisa Rogers</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-013694B</b>		17. INFORMANT <b>BCH-Records 4940 Eastern Avenue 21224</b>	
18. <b>593.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Severe Pneumonia, prob. Pneumococcal</b> (B) <b>Congestive Heart Failure</b> (C) <b>Chronic Renal Insufficiency</b> <b>Anemia, Uremia, Acidosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>1-2 weeks</b> <b>2-3 years</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>Oct. 9, 1971</b> 19 to <b>Oct 11, 1971</b> 19 that (1) (we) last saw the deceased alive on <b>Oct 11, 1971</b> 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William P. Hunt, M.D.</b>				23B. DATE SIGNED <b>Oct. 11, 1971</b>	
23C. PHYSICIAN'S NAME (Type) <b>William P. Hunt, M.D.</b>		23D. ADDRESS <b>BCH 4940 Eastern Avenue Baltimore, Maryland 21224</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-14-71</b>		24C. NAME of CEMETERY or CREMATORY <b>MOUNT CALVARY CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>ANNE ARUNDEL Co., Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>Randolph J. Gallick</b>		25C. FUNERAL DIRECTOR <b>2431 E. Oliver St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 9416	
BIRTH NO. <u>D-525</u>				71 9416	
71 9416				71 9416	
1. NAME OF DECEASED (Type or Print) <u>Dunnigan Mrs Loretta A.</u>			2. DATE AND HOUR OF DEATH <u>10/11/71 3:45 PM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2864</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secour Hospital</u>			C. CITY OR TOWN <u>Baltimore</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>F</u>			6. RACE <u>White</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>3/1/92</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			9. AGE (In years last birthday) <u>79</u>		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>Frank Hammett (deceased)</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>215-03-1537B</u>		
17. INFORMANT <u>Howard F. Dunnigan</u>			ADDRESS <u>402 Swann Avenue 21229</u>		
18. <u>433.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral thrombosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>10/8</u> 19 <u>71</u> to <u>10/11</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10/10</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Masahiro Sugawara</u>			23B. DATE SIGNED <u>10/11-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>MASAHIRO SUGAWARA</u>			23D. ADDRESS <u>BON SECOUR HOSPITAL BALTIMORE Md. 21223</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>10/13/71</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>			24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1971</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		
25C. FUNERAL DIRECTOR <u>Witake</u>			ADDRESS <u>1630 Edmondson Avenue 21228</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-530 71 9417		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Ruby Hunt</i>		2. DATE AND HOUR OF DEATH <i>Oct. 10, 1971 1:20 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2506</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hospital</i>		C. CITY OR TOWN <i>Balti.</i>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>Female</i> 6. RACE <i>Negro</i>		E. STREET AND NUMBER <i>3207 Sun St.</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-3-06</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		9. AGE (in years last birthday) <i>65</i>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Oregan Brooks</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Martin</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Samuel Hunt-Husband</i>	
18. <i>2507 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Pul. edema</i> (B) <i>Renal failure</i> (C) <i>Diabetes mellitus</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10/8</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examination)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Oct. 8</i> 19 <i>71</i> to <i>Oct. 10</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>Oct. 10</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Young</i>		23B. DATE SIGNED <i>10/10/71</i>	
23C. PHYSICIAN'S NAME (Type) <i>YOUNG SOOK Kim, M.D.</i>		23D. ADDRESS <i>Lutheran Hosp. of Maryland</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-13-71</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 12 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>V. Bailey</i>		ADDRESS <i>1348 Calhoun Street</i>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525 71 9418		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9418	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>JOHNSON, Mary L.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>10-6-71</u> <u>12:05</u> A.M.			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1303</u>		C. CITY OR TOWN <u>Baltimore</u>	
5. SEX <u>Female</u>		6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>9/9/08</u>	
13. FATHER'S NAME <u>John Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Miller</u>		9. AGE (In years last birthday) <u>63</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mabel Williams</u>	
18. <u>436.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>2</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CAUSE OF DEATH</u> (A) IMMEDIATE CAUSE <u>Gm Neg Bacteremia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Probable Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Cerebral Edema + SP Carotid Endarterectomy</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
23A. SIGNATURE <u>J. Jones</u>		23B. DATE SIGNED <u>10-6-71</u>		23C. PHYSICIAN'S NAME (Type) <u>John Jones, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-9-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Bailey, M.D.</u>		25C. FUNERAL DIRECTOR <u>V. Bailey</u>	
26. ADDRESS <u>1348 Calhoun St.</u>		27. ADDRESS <u>1348 Calhoun St.</u>		28. ADDRESS <u>1348 Calhoun St.</u>	

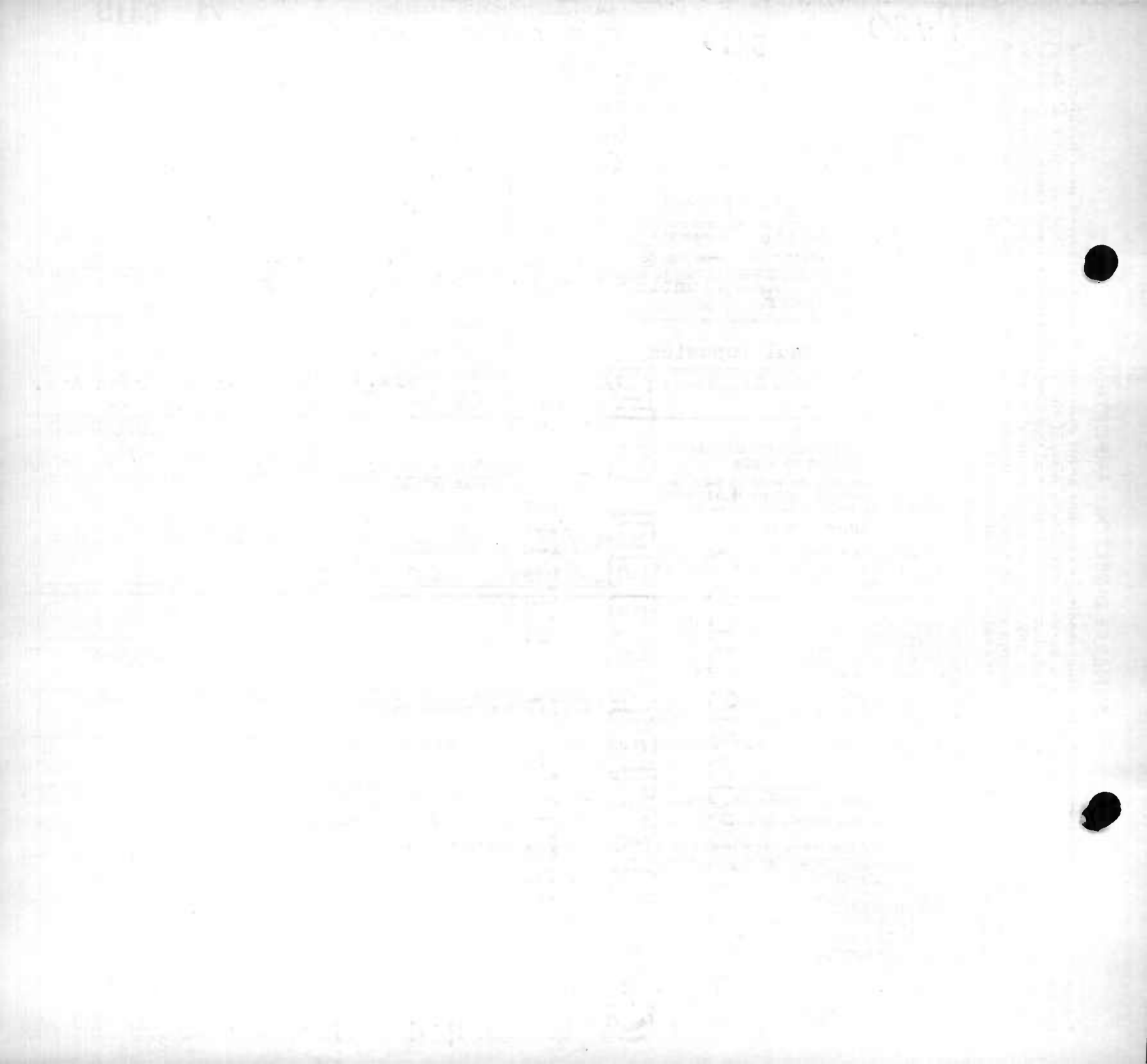
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">71 9419</span>	
P-120 71 9419		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Frank T. Popowicz</u>		2. DATE AND HOUR OF DEATH <u>10/10/71</u> <u>730</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>South Baltimore General Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>201</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2115 Chapel St.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/6/09</u>	9. AGE (In years last birthday) <u>62</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Checker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Plumbing Fixtures</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Paul</u> Paul Popowicz		14. MOTHER'S MAIDEN NAME <u>Mary Carper</u> Mary Carper			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-05-3961</u>		17. INFORMANT <u>Mrs. Gloria Lee, 6925 Stanford J Huber</u> ADDRESS <u>Brown Ave. 586-A</u>	
18. <u>410.9</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory &amp; Cardiac arrest</u>		<u>1 hour</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Recent Massive Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>1 day</u>	
(C) <u>ASCVD, COPD</u>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 9</u> 19 <u>71</u> to <u>Oct 10</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Oct 10</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stanford J. Huber MD</u> DEGREE <u>MD</u>				23B. DATE SIGNED <u>10/10/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Stanford J. Huber</u> DEGREE <u>MD</u>				23D. ADDRESS <u>3001 S. Hanover St.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/13/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>M. F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</u>			

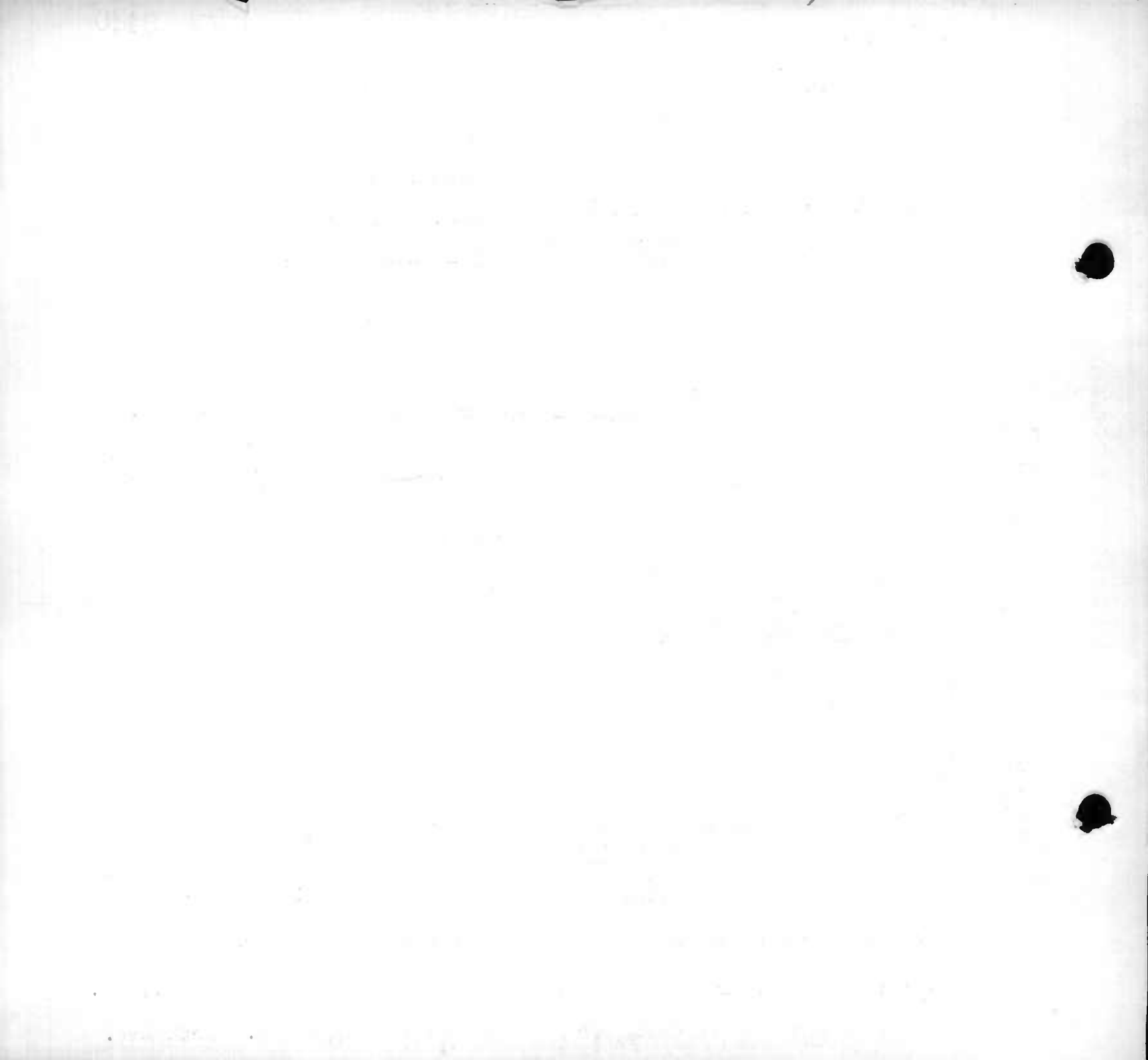


Cox, Lillie 37 33 #1

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-200 71 9420		BALTIMORE CITY HEALTH DEPARTMENT		71 9420	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Lillie Cox		2. DATE AND HOUR OF DEATH 10/7/71 3:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY City BALTO 5300 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3507 Woodlawn Ave			
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-09-14	9. AGE (in years last birthday) 56	11. BIRTHPLACE (State or foreign country) North Carolina
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Ada		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 240-03-8349		17. INFORMANT ADDRESS Sarah Boles 3006 Wylie Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction</i> (B) <i>Sepsis</i> (C) <i>Unemia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>60 minutes</i> <i>5 days</i> <i>4 years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>marked Hypercalcemia; Pleural Effusion; Pleural granuloma; pneumonia, UTI, Anemia</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from July 1, 1971 to July 7, 1971 that (1) (we) last saw the deceased alive on July 7, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas Knight Hodous, M.D.				23B. DATE SIGNED 10/7/71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Thomas Knight Hodous		The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		10-11-71		Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State)		Anne Arundel City., Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 12 1971		Robert E. Taylor, R.D.		Wm C March 928 E. North Ave.	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9421</u>	
BIRTH NO. <u>C-320 71 9421</u>		1. NAME OF DECEASED (Type or Print) <u>JANIN James L. Cates</u>		2. DATE AND HOUR OF DEATH <u>Oct 8, 1971</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 Johns Hopkins Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>806</u>		
5. SEX <u>Male</u> 6. RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>8-11-14</u> 9. AGE (In years last birthday) <u>57</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Pete Cates</u>			14. MOTHER'S MAIDEN NAME <u>Lou Ann Saterfield</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>239-10-1370</u>		17. INFORMANT <u>Helen E. Cates</u> ADDRESS <u>1621 N. Durham St.</u>
18. <u>412.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Hypertensive Cordis Vasculi ?</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Disease</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 4</u> 19 <u>70</u> to <u>Oct 8</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Feb 8</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>F.K. Adams</u>				23B. DATE SIGNED <u>10-12-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>F.K. ADAMS</u>				23D. ADDRESS <u>1222 N. Caroline St.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-13-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Balto Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Balto., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Wm C. March</u>		ADDRESS <u>928 E. North Ave.</u>	

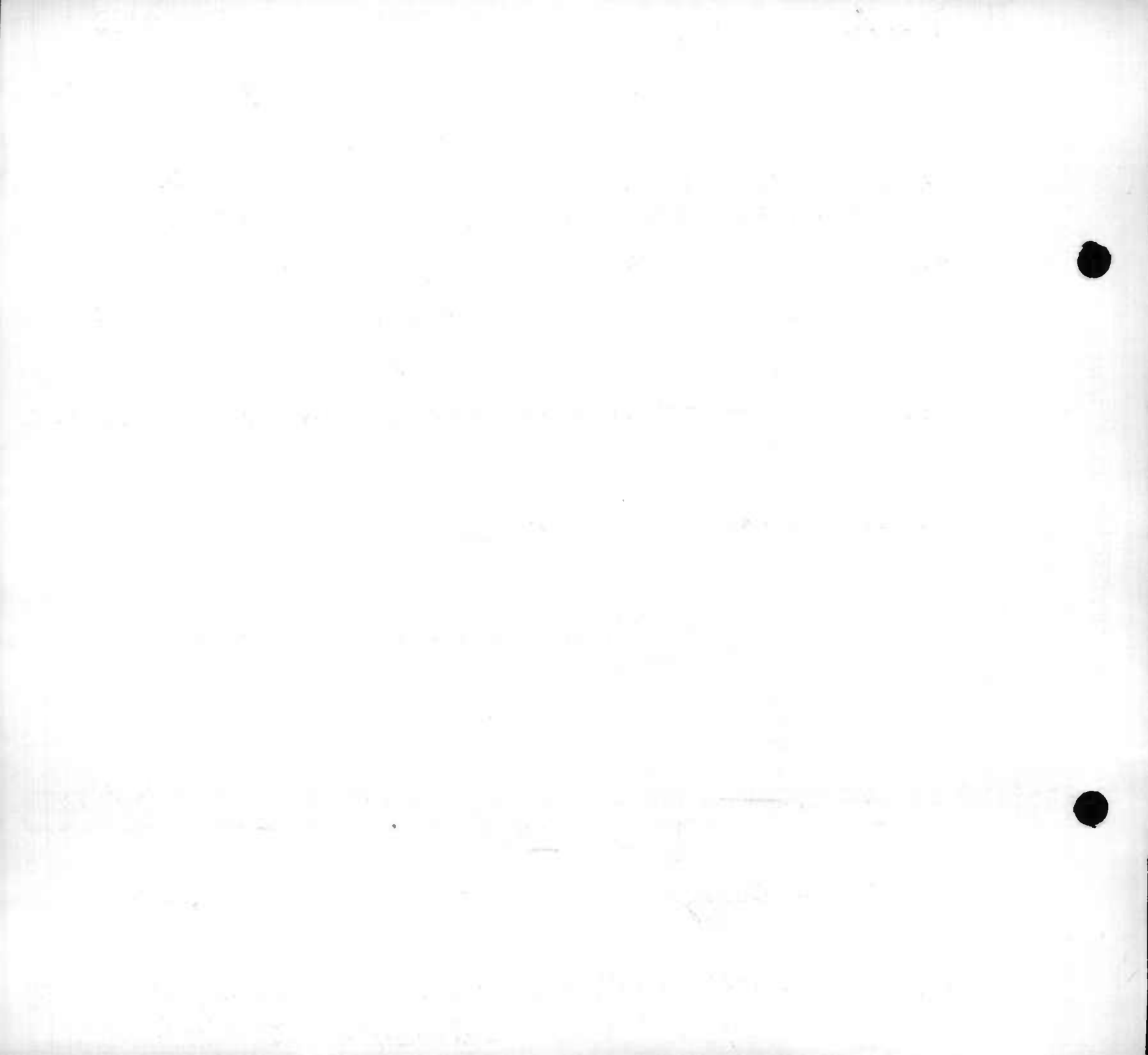




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">71 9422</span>
D-640 71 9422		BIRTH NO.		
1. NAME OF DECEASED (Type or Print) <b>JOHN DROLL</b>		2. DATE AND HOUR OF DEATH <b>10/7/71 10:15 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>HOUSE OF PINES NURSING HOME 13 ELAIR RD BALTO, MD</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>2632</b>		
		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>4309 FRANKFORD AVE</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 7, 1880</b>	9. AGE (in years last birthday) <b>91</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <b>IM HOF</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>242-09-2805</b>		17. INFORMANT <b>LOUISE HINKE</b>
18. <b>437.9 14250.9</b>		CAUSE OF DEATH		ADDRESS <b>5500 GOWANE AVE</b>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtemia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Multiple Sclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days - weeks</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>year</b>
(C) _____				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes mellitus; Arteriosclerotic Heart Disease; Gout</b>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>6/2/1971</b> to <b>10/7/1971</b> that (I) <del>(we)</del> last saw the deceased alive on <b>10/5/1971</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(didn't)</del> view the body after death.				
23A. SIGNATURE <b>Alfred B. Bruckey</b>		23B. DATE SIGNED <b>10/7/71</b>		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
DEGREE				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-11-71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b>
24D. LOCATION (City, town, or county) (State) <b>BALTO MD</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Frederick F. Cook</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9423</span>	
D-640 71 9423				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		DROLL MRS. AGNES.		2. DATE AND HOUR OF DEATH 10-8-1971 3:30 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MD USA.	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL 5100 N. Broadway, Balto MD 21231				C. CITY OR TOWN Baltimore.	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4309 Frankford Ave. 21206.	
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-05-1896	9. AGE (In years last birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Household.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME Bernard Heuberger.				14. MOTHER'S MAIDEN NAME Katherine Herring.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215 12 288		17. INFORMANT Mrs. Louise Heiber Frankford Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-Respiratory failure 10 days (B) Metastatic Carcinoma abdomen ? (C)	
19A. DATE OF OPERATION 9-20-1971		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Mass in abdomen		20A. AUTOPSY? (Yes or No) -	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-10-1971 to 10-8-1971 that (I) (we) last saw the deceased alive on 10-8-1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Mehta				23B. DATE SIGNED 10-8-1971	
23C. PHYSICIAN'S NAME (Type) Dr. A. MEHTA				23D. ADDRESS Church Home & Hosp. 5100 N. Broadway Balto MD 21231	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-12-71		24C. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY	
				24D. LOCATION (City, town, or county) (State) TAYLOR AVE BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. OCT 12 1971		25B. NAME OF REGISTRAR Robert E. Galt, M.D.		25C. FUNERAL DIRECTOR Cook 7200 Frankford Road	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

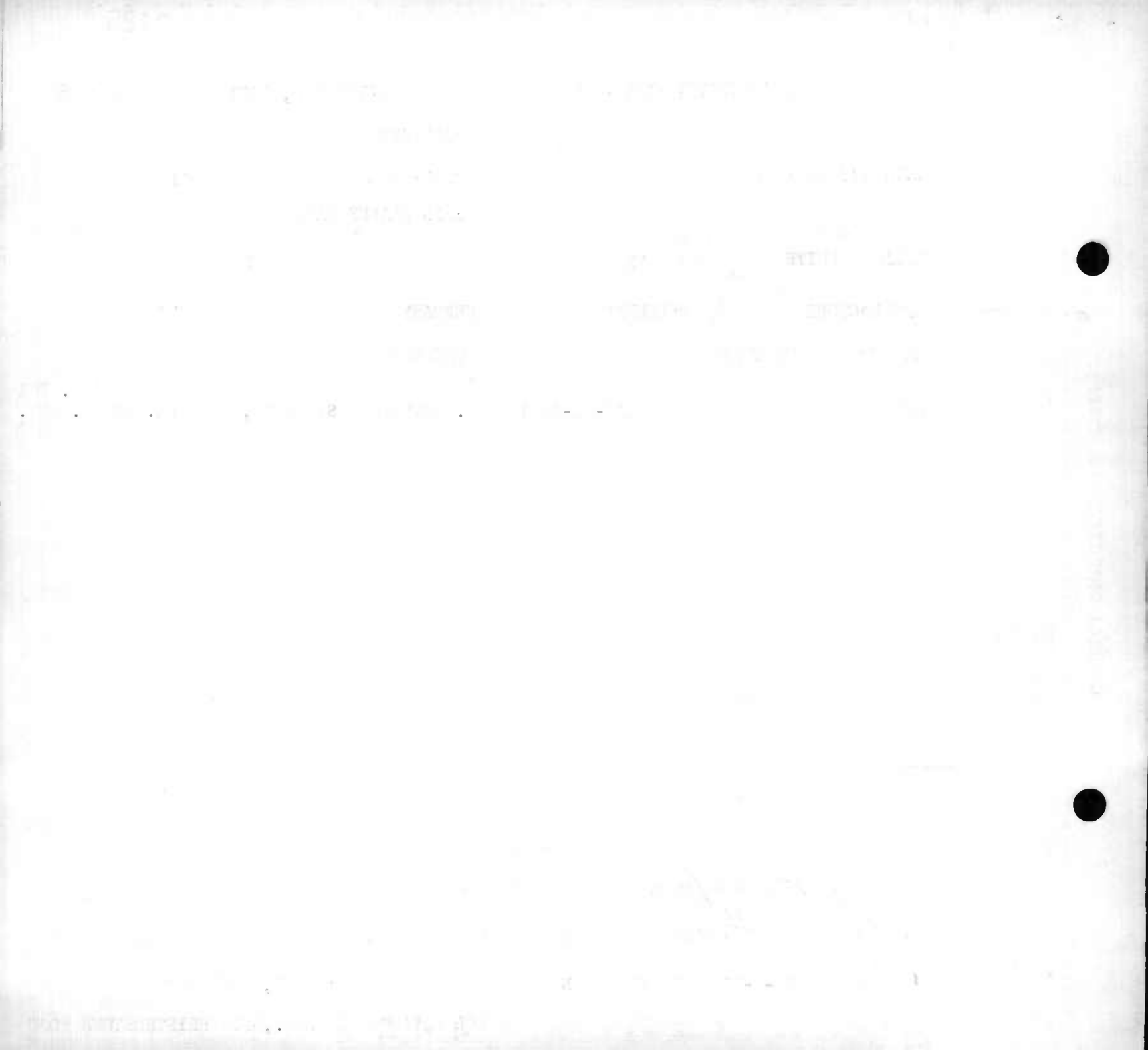
1. NAME OF DECEASED (Type or Print) <b>Leroy Branchley-Branchbey</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>10</b> Day <b>4</b> Year <b>71</b> Hour <b>11:20</b> A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>34 Bon Secour Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>4</b> Year <b>71</b> Hour <b>11:20</b> A.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1901</b>			
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>10-13-23</b>	10. AGE (In years last birthday) <b>47</b>	E. STREET AND NUMBER <b>1527 W. Lexington Street</b>	
11. BIRTHPLACE (State or foreign country) <b>Va</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>L Construction</b>		15. MOTHER'S MAIDEN NAME <b>Lillian ?</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW-2</b>		17. SOCIAL SECURITY NO. <b>215-16-5515</b>	
18. INFORMANT <b>Geraldine Eaton-3449 Childa Ct-</b>		ADDRESS	
19. CAUSE OF DEATH <b>E 965X I</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Gunshot wound of neck</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) _____	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>House</b>	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <b>1527 W. Lexington Street</b>		22F. HOW DID INJURY OCCUR? <b>Shot during argument</b>	
22D. TIME OF INJURY (APPROX.) <b>10 2 71 12:40 A.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. EXAMINER'S NAME (Type) DATE SIGNED <b>10-5-71</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10-II-71</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mount Calvary</b>	24D. LOCATION (City, town, or county) (State) <b>A A Co., Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>	25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>	25C. FUNERAL DIRECTOR <b>Isaiah L. Brown &amp; Son</b> <b>123 W. Montgomery Street</b>	

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9425</span>	
<div style="font-size: 1.5em; font-family: cursive;">W-635 71 9425</div>				<div style="font-size: 1.5em; font-family: cursive;">71 9425</div>	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)				OCTOBER 6, 1971 <span style="float: right;">10 P. M.</span>	
GUS (GUSTAVE) WERTHEIM					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  3939 CLARKS LANE  00				A. STATE MARYLAND	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3939 CLARKS LANE	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 93	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANUFACTURE		10B. KIND OF BUSINESS OR INDUSTRY NECKWEAR	11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME UNKNOWN WERTHEIM			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-01-3861	17. INFORMANT MRS. ESTELLE WERTHEIMER, 6210 PK. HIGHTS. AVE. APT. 701		
18. <span style="font-size: 1.5em; font-family: cursive;">4123 I</span> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			ARTERIO SCLEROTIC Heart Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CHRONIC Iron Deficiency Anemia <span style="float: right;">20 YRS.</span>		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em; font-family: cursive;">Jan 15</span> 19 <span style="font-size: 1.5em; font-family: cursive;">49</span> to <span style="font-size: 1.5em; font-family: cursive;">Oct 6</span> 19 <span style="font-size: 1.5em; font-family: cursive;">71</span> and that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em; font-family: cursive;">Oct 6</span> 19 <span style="font-size: 1.5em; font-family: cursive;">71</span> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em; font-family: cursive;">Gilbert J. Himezfarb</span>				23B. DATE SIGNED Oct 6, 1971	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em; font-family: cursive;">Gilbert J. Himezfarb</span>				23D. ADDRESS <span style="font-size: 1.5em; font-family: cursive;">222 W. Cold Spring Lane - Balto. Md.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-8-71		24C. NAME OF CEMETERY or CREMATORY HEBREW FRIENDSHIP	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. OCT 12 1971			
25B. NAME OF REGISTRAR <span style="font-size: 1.5em; font-family: cursive;">Robert E. ...</span>		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

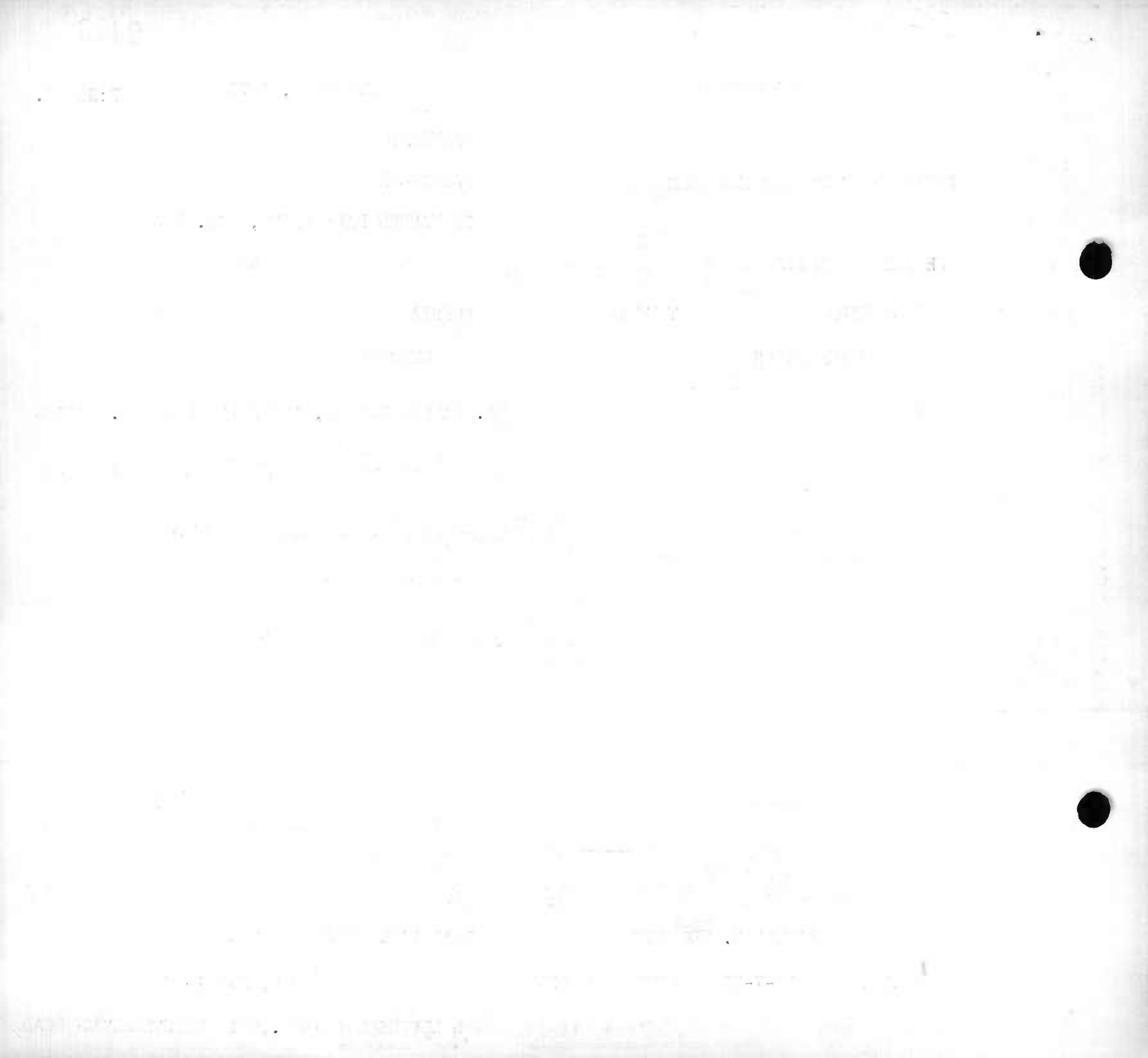




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. <u>71 9426</u>	
Z-260 <u>71 9426</u>				<b>CERTIFICATE OF DEATH</b>			
BIRTH NO. <u>71 9426</u>				1. NAME OF DECEASED (Type or Print) <u>ANNA ZUCKER</u>			
2. DATE AND HOUR OF DEATH <u>OCTOBER 6, 1971</u> <u>7:30 A.M.</u>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>PLEASANT MANOR NURSING HOME</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>PLEASANT MANOR NURSING HOME</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>15 WARREN PARK DRIVE, APT. B 4</u>							
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>80</u>	9. AGE (In years last birthday) <u>80</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HIRSCH SCHNEIDER</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>MR. SAMUEL ZUCKER, 15 WARREN PARK DR. #21208</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>4/12/41 250-9</u> <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Cardio Vascular</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Diabetes Mellitus</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Feb 6, 1951</u> to <u>Oct 6, 1971</u> that (I) (we) last saw the deceased alive on <u>Oct 5, 1971</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Samuel V. Tompakov</u>				23B. DATE SIGNED <u>Oct 6, 1971</u>			
23C. PHYSICIAN'S NAME (Type) <u>SAMUEL V. TOMPAKOV</u>				23D. ADDRESS <u>7211 PARK HEIGHTS AVENUE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10-7-71</u>		24C. NAME of CEMETERY or CREMATORY <u>WORKMEN CIRCLE</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, R.C.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9427</span>	
<div style="font-size: 2em; font-weight: bold;">S-20071 9427</div>				<div style="font-size: 1.5em; font-weight: bold;">CERTIFICATE OF DEATH</div>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Sida Suci</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">October 8, 1971</span> <span style="float: right;">12:45 A.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">1236 Glyndon Avenue 21223</span>				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">2102</span>	
				C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <span style="font-size: 1.2em;">1236 Glyndon Avenue 21223</span>	
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.2em;">08/12/95</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">76</span>
				If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Feller</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Clothing Co.</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Romania</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>				13. FATHER'S NAME <span style="font-size: 1.2em;">Florut</span>	
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Unknown</span>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>	
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-26-1233</span>				17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Dimitrie Suci 1236 Glyndon Avenue 21223</span>	
18. <span style="font-size: 1.5em;">412.3 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Arteriosclerosis of heart</span>					
19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">6 months</span>					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">II</span>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
21A. DATE OF OPERATION <span style="font-size: 1.2em;">D</span>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21G. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21H. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21I. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <span style="font-size: 1.2em;">Nov. 19 57</span> to <span style="font-size: 1.2em;">Oct 8, 1971</span> 19 <span style="font-size: 1.2em;">57</span> that (I) ( <del>was</del> ) last saw the deceased alive on <span style="font-size: 1.2em;">Oct. 6, 1971</span> 19 <span style="font-size: 1.2em;">57</span> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Morris B. Schreiber M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">10-9-71</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">MORRIS B. SCHREIBER</span>				23D. ADDRESS <span style="font-size: 1.2em;">1519 W. Lombard St. Baltimore Md. 21223</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">10/11/71</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Loudon Park Cemetery</span>	
24D. LOCATION <span style="font-size: 1.2em;">Baltimore City, Maryland</span>		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR <span style="font-size: 1.2em;">OCT 12 1971</span>	
24G. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Baker, Jr.</span>		24H. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Walters Funeral Home</span>		24I. ADDRESS <span style="font-size: 1.2em;">Pratt &amp; Stricker Streets 21223</span>	

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BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

~~XXXXXXXXXX~~ Jeffrey Scott Winslow4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

HOSPITAL

OR INSTITUTION

40 St. Agnes Hospital

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

March 3, 1962

10. AGE (In years lost birthday)

9 1/2

If Under 1 Yr. II Under 24 Hrs.

Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF

WHAT COUNTRY?

U.S.A.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Child

14B. KIND OF BUSINESS OR INDUSTRY

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Mr. James R. Winslow, 1209 Greystone Rd. 21227

19.

E 813.6

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Multiple Injuries

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS

UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location)

INJURY OCCUR?  
Southwestern Blvd. 2551

22D. TIME (Month) (Day) (Year) (Hour)

OF INJURY (APPROX.) 10 8, 1971 5:40 PM

22E. INJURY OCCURRED

WHILE AT

m. WORK ☐

NOT WHILE

AT WORK ☒

22F. HOW DID INJURY OCCUR?

struck by car while riding his bicycle

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Werner U. Spitz, M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10/9/71

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10-11-1971

24C. NAME of CEMETERY or CREMATORY

Meadowridge Cemetery

24D. LOCATION (City, town, or county) (State)

Washington Blvd. Howard Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

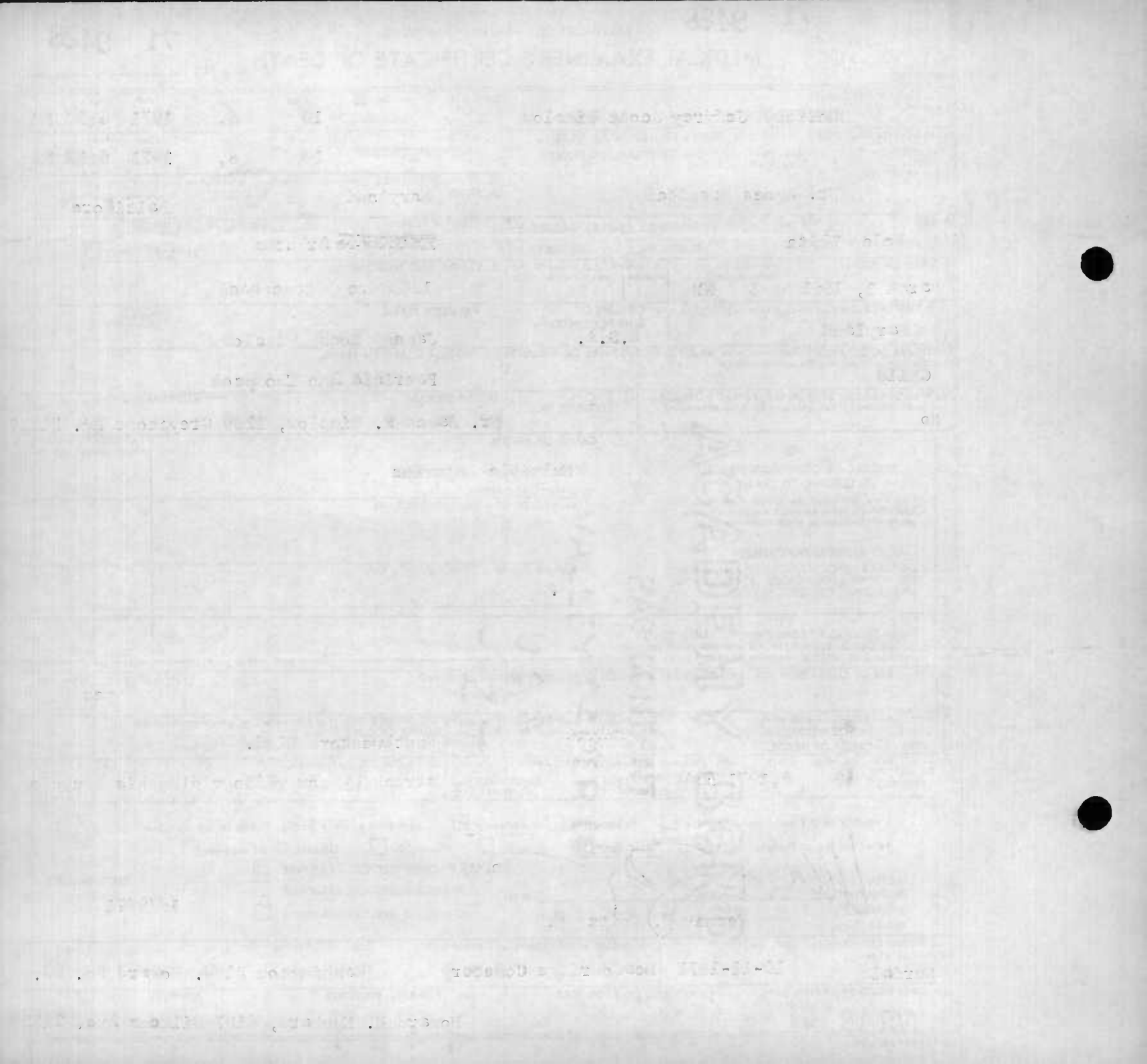
25C. FUNERAL DIRECTOR

ADDRESS

OCT 12 1971

Robert E. Taylor, M.D.

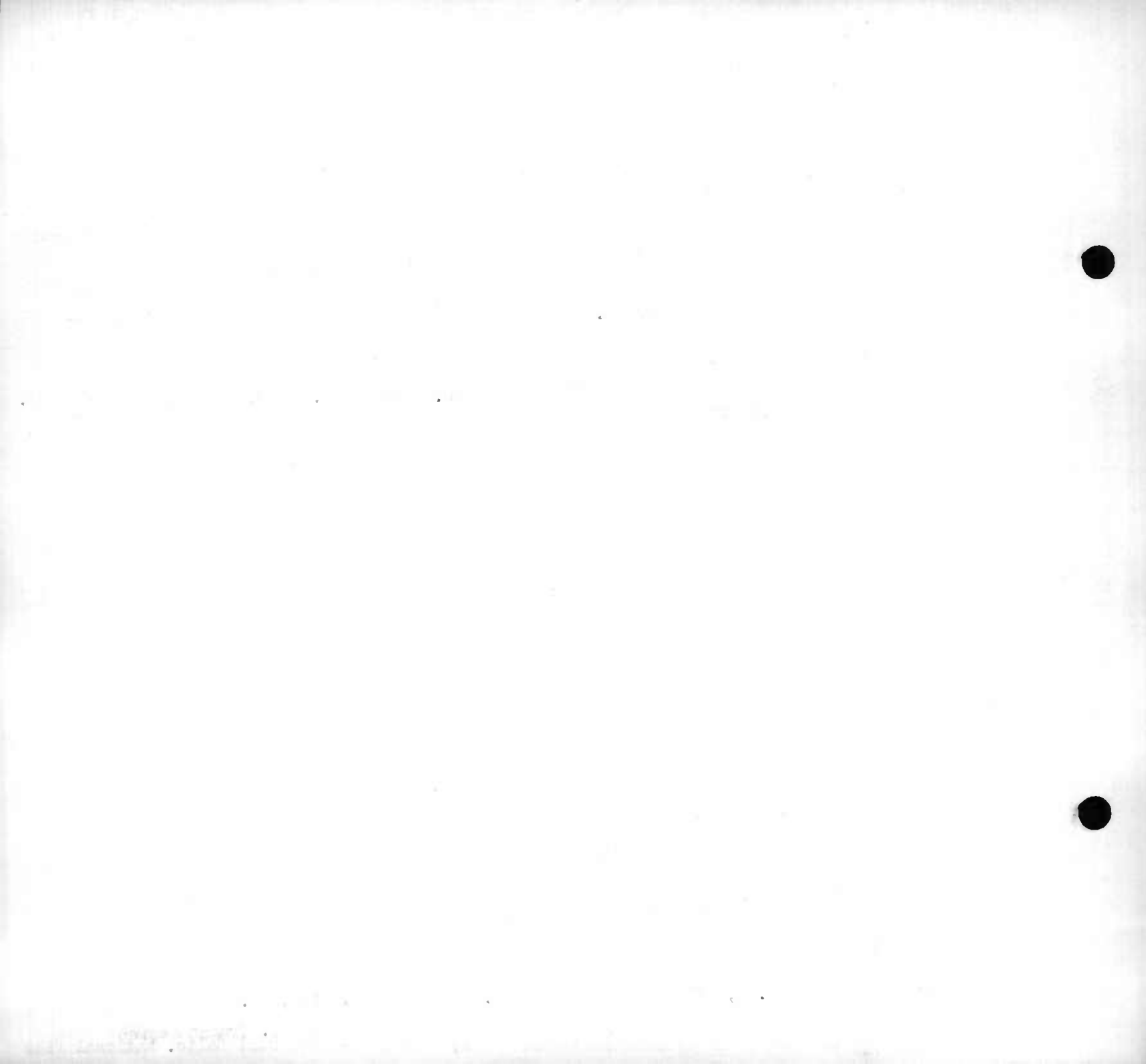
Howard H. Hubbard, 4107 Wilkens Ave. 21229



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<h2 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h2> <h3 style="margin: 0;">CERTIFICATE OF DEATH</h3>		REG. NO. <span style="font-size: 1.5em;">71 9429</span>	
BIRTH NO. <span style="font-size: 1.5em;">G-650 71 9429</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.5em;">10/8/71 6:10 AM</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.5em;">Green, Wilfred, Jr.</span>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <span style="font-size: 1.5em;">MARYLAND</span> BALTO 5300 B. COUNTY <span style="font-size: 1.5em;">BALTIMORE</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">BON SECOURS HOSPITAL 34</span>		C. CITY OR TOWN <span style="font-size: 1.5em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.5em;">5515 Old Frederick Rd</span>	
5. SEX <span style="font-size: 1.5em;">male</span>	6. RACE <span style="font-size: 1.5em;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.5em;">12/24/13</span> 9. AGE (In years last birthday) <span style="font-size: 1.5em;">57</span> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">Disability</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.5em;">Koppers Co.</span>	
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">MARYLAND</span>		12. CITIZEN OF WHAT COUNTRY <span style="font-size: 1.5em;">USA</span>	
13. FATHER'S NAME <span style="font-size: 1.5em;">Lawrence Green</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">Cain Rachel Cain</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">Unknown no</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.5em;">217-092727</span>	
17. INFORMANT <span style="font-size: 1.5em;">Mrs. Marjorie L. Green</span> ADDRESS <span style="font-size: 1.5em;">5515 Old Frederick Rd.</span>		18. CAUSE OF DEATH <span style="font-size: 1.5em;">150X I</span>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <span style="font-size: 1.5em;">Carcinoma of Esophagus.</span> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <span style="font-size: 1.5em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <span style="font-size: 1.5em;">No</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month, Day, Year, Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">October 5, 1971</span> to <span style="font-size: 1.5em;">October 8, 1971</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">October 8, 6:10 am 1971</span> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.5em;">Pimpa Metaronarat</span>		23B. DATE SIGNED <span style="font-size: 1.5em;">October 8, 1971</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">PIMPA METARONARAT M.D.</span>		23D. ADDRESS <span style="font-size: 1.5em;">BON SECOURS HOSPITAL BALTIMORE, Md. 21228.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">Burial</span>	24B. DATE <span style="font-size: 1.5em;">Oct. 11, 1971</span>	24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.5em;">Poplar Spring Cem.</span>	24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.5em;">Mt. Airy, Md.</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">OCT 12 1971</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Taylor, Jr.</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">J. J. KUBAB</span>		ADDRESS <span style="font-size: 1.5em;">G. Truman Schwab 5151 Balto. National Pike</span>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 71 9430	
L-200 71 9430				BIRTH NO.			
1. NAME OF DECEASED (Type or Print) HARRY C. LEAKE JR				2. DATE AND HOUR OF DEATH Oct 8 1971 8:40 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL				A. STATE VIRGINIA			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN CHARLOTTESVILLE			
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER 105 GARDEN DRIVE			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/30/29	9. AGE (In years last birthday) 41	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police Officer				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Alberene, Virginia	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME HARRY C. LEAKE			
14. MOTHER'S MAIDEN NAME LENNIE PAGE				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean			
16. SOCIAL SECURITY NO. 229 30 8684				17. INFORMANT Dorothy Durrer Leake, 105 Garden Drive Charlottesville, Va.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: VENTRICULAR ASYSTOLE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 MIN	
				(B) ACUTE MYOCARDIAL INFARCTION VS DUE TO, OR AS A CONSEQUENCE OF:		20 MIN	
				(C) PULMONARY EMBOLISM		5 DAYS	
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/2 1971 to 10/8 1971 that (I) (we) last saw the deceased alive on 10/8 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Keith J. Klein M.D.				23B. DATE SIGNED 10/8/71		23C. PHYSICIAN'S NAME (Type) DR. KEITH KLEIN M.D.	
23D. ADDRESS Johns Hopkins Hospital				23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-11-71		24C. NAME OF CEMETERY or CREMATORY Holly Memorial Garden		24D. LOCATION (City, town, or county) (State) Charlottesville Va.	
25A. DATE REC'D BY HEALTH DEPT. OCT 12 1971		25B. NAME OF REGISTRAR Robert E. Taylor Jr.		25C. FUNERAL DIRECTOR Howard H. Hubbard		25D. ADDRESS 4107 Wilkens Ave. 21229	

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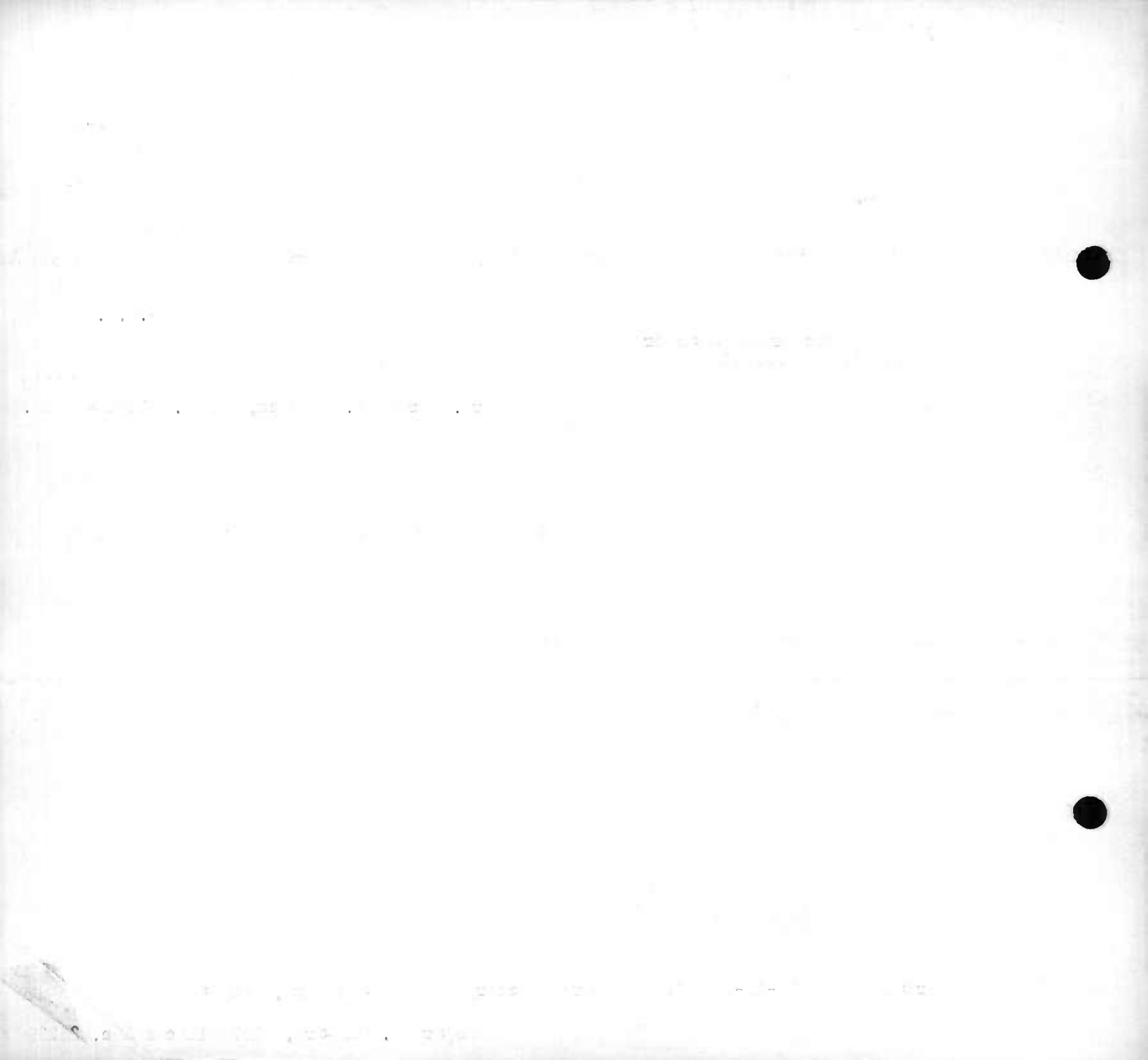
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-526 71 9431		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9431	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CARL BECKER ANACKER		OCT 9, 1971 545 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
South Baltimore General Hospital 43			MARYLAND ANNE ARUNDEL 5200		
C. CITY OR TOWN			D. INSIDE CITY LIMITS?		
Linthicum Heights			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER			405 W. CLEVELAND ROAD		
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
				9. AGE (In years last birthday)	
				12/16/94 76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
Retiree			11. BIRTHPLACE (State or foreign country)		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Frederick Anacker			EMMA BECKER (dec)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		ADDRESS
No			217094930A		21090
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
I			Acute Myo Infarction 1 day		
II			Arteriosclerotic Cardiovascular > 10 years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			Congestive Heart Failure > 10 years		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)		21E. HOW DID INJURY OCCUR?	
21F. HOW DID INJURY OCCUR?		21G. INJURY OCCURRED		21H. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		22. I certify that (I) (this hospital) attended the deceased from 19 to 19		that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE			23B. DATE SIGNED		DEGREE
R. F. ABOUTY			10/7/71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
R. F. ABOUTY			DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		10-13-71		Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
Baltimore, Maryland		OCT 12 1971		Howard H. Hubbard	
25C. FUNERAL DIRECTOR		ADDRESS		4107 Wilkens Ave. 21229	



1

B-530 71 9432

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 9432

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DONALD T. BENNETT		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> October 6, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour October 6, 1971 4:05 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Feb. 15, 1912		10. AGE (In years last birthday) 59	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W. II		17. SOCIAL SECURITY NO. 705 12 7737	
18. INFORMANT Marie Peyton		ADDRESS 1512 Ramsey St.	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 1		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct. 11, 1971	
24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 12 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Thomas J. Henry, Inc.		ADDRESS 1600 Hollins St.	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>71 9433</b>
BIRTH NO. <b>B-420</b>		71 9433		
1. NAME OF DECEASED (Type or Print) <b>Charles E. Blake</b>		2. DATE AND HOUR OF DEATH <b>Oct. 8, 1971</b> <b>6:45 A.</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>833</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 3214 Belair Road</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Oct. 24, 1903</b>		9. AGE (in years last birthday) <b>67</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Night Watchman</b>
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>Charles E. Blake</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Stumo</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-10-1768</b>		17. INFORMANT <b>Elsie C. Blake-3214 Belair Rd.-21213</b>
18. <b>492 X 4011.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Chronic Emphysema</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Pulmonary tuberculosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr?</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1970</b> to <b>10-8-1971</b> that (I) (we) last saw the deceased alive on <b>Sept 27 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>J. Duver Moore M.D.</b>				23B. DATE SIGNED <b>10-11-71</b>
23C. PHYSICIAN'S NAME (Type) <b>J. DUVER MOORES M.D.</b>		23D. ADDRESS <b>3105 1/2 Belair Rd. Balto. Md. 21213</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-12-71</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>
24D. LOCATION (City, town, or county) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		
25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.P.</b>		25C. FUNERAL DIRECTOR <b>John S. Miller Inc-6415 Belair Rd.-21206</b>		

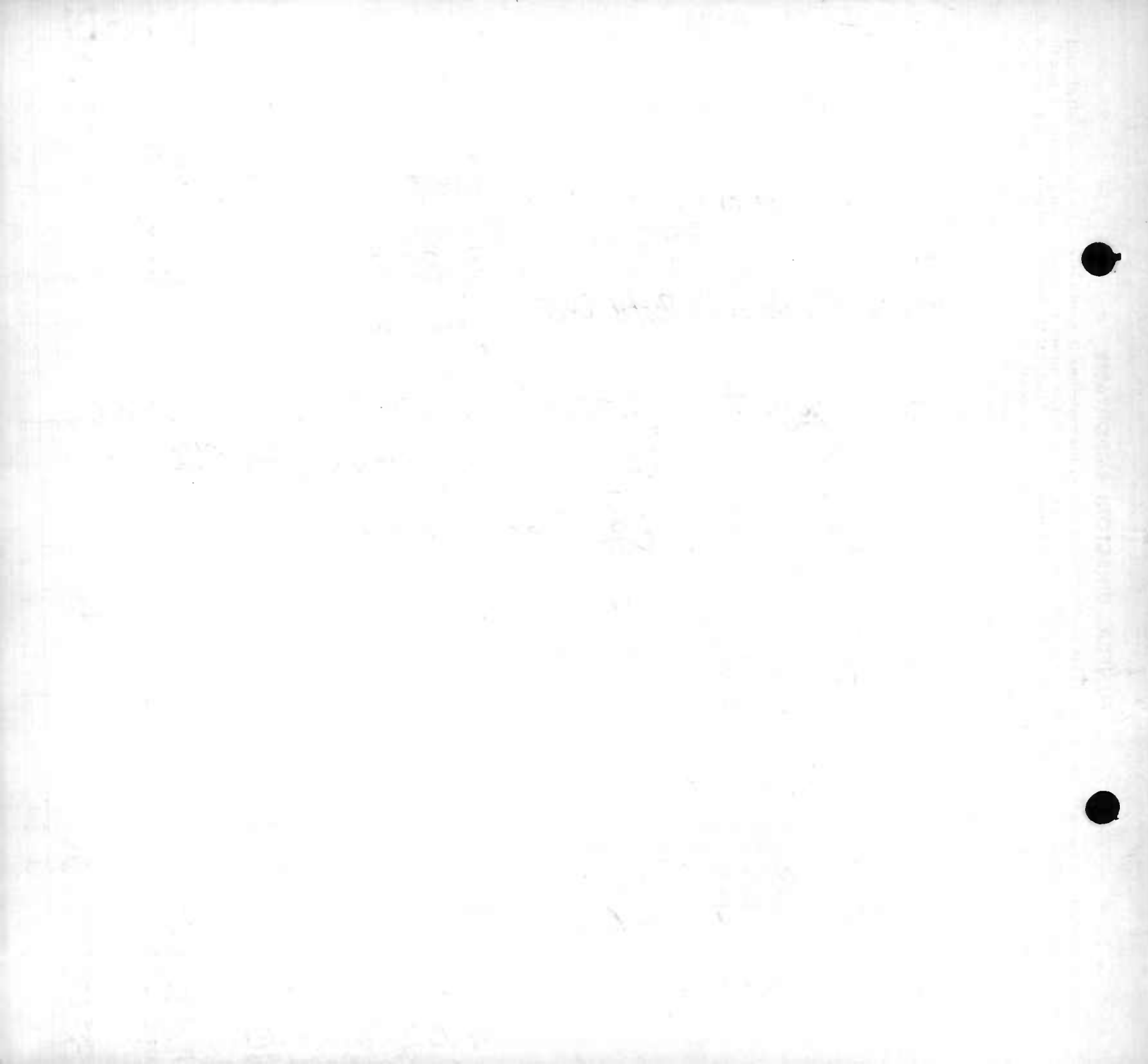




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 9434	
BIRTH NO. 7-152 71 9434		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) EVANS, WENDELL E.		2. DATE AND HOUR OF DEATH 10-7-71 755 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		A. STATE MD		B. COUNTY 1348	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1313 WELDON AVENUE			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-09-88	9. AGE (in years last birthday) 83	10. Under 1 Yr. Months Days Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Employee US Postal Dept.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME EUGENE EVANS		14. MOTHER'S MAIDEN NAME PRICE, SUSANNO	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. T 217525459		17. INFORMANT *Myrtle F EVANS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
E8805K		PULMONARY Embolism		10 days	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: FRACTURE R Hip.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
CHRONIC OBSTRUCTIVE Lung Disease.		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 19/27/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fract. R Hip		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home - Floor.		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Home 1313 Weldon Ave	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 9 26 71 11:30		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell - slipped 1348	
22. I certify that (I) (this hospital) attended the deceased from 9-27-71 to 10-7-71 and that (I) (we) last saw the deceased alive on 10-7-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carlos A. Bettrick MD		23B. DATE SIGNED 10-7-71		23C. PHYSICIAN'S NAME (Type) Carlos A. Bettrick MD	
23D. ADDRESS 1313 WELDON AVENUE		23E. DATE SIGNED		23F. PHYSICIAN'S NAME (Type)	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9 Oct 71		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem	
24D. LOCATION Woodlawn Balto Co Md		24E. DATE REC'D BY HEALTH DEPT. OCT 12 1971		24F. NAME OF REGISTRAR Robert E. [unclear]	
24G. FUNERAL DIRECTOR Burgess Funeral Home Balto Md		24H. ADDRESS		24I. DATE SIGNED	



BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 9435  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Clinton E. Trout		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 5 Year 71 Hour 3:20 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2124 Maryland Avenue		3. DATE PRONOUNCED DEAD Month 10 Day 5 Year 71 Hour 3:20 P.M.	
6. SEX male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Sept 28 1915		10. AGE (in years last birthday) 56	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		14B. KIND OF BUSINESS OR INDUSTRY Detective Agency	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		17. SOCIAL SECURITY NO. 218 05 0882	
15. MOTHER'S MAIDEN NAME Blanche Peacock		18. INFORMANT Stella Trout	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cirrhosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/6/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9 Oct 71	
24C. NAME of CEMETERY or CREMATORY Reisterstown Cemetery		24D. LOCATION (City, town, or county) (State) Reisterstown, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 12 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Burgee Funeral Home, Baltimore Maryland		25D. ADDRESS By <i>Veronica B. Burch</i>	

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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>71 9436</b>	
P-360 71 9436					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LOIS BETTY PETRY</b>		2. DATE AND HOUR OF DEATH <b>OCTOBER 5 2:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>UNION MEMORIAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>CARROLL</b> C. CITY OR TOWN <b>WESTMINSTER</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>RT. 14, TANNERY ROAD</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44</b>		5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>06-08-25</b> 9. AGE (In years last birthday) <b>46</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>EDRL CORNELIUS Mathias</b>		14. MOTHER'S MAIDEN NAME <b>IRMD MASON HEIMER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219 188 531</b>		17. INFORMANT <b>Mrs Nancy Felter</b> ADDRESS <b>1250 Medfield Ave</b>	
18. <b>5-7-79 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE <b>METABOLIC ACIDOSIS</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>SEPTIC SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) <b>LIVER CIRRHOSIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>10-8-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 4 1971</b> to <b>OCTOBER 5 1971</b> that (I) (we) last saw the deceased alive on <b>OCTOBER 5 1971</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>C. E. M. R.</b>		23B. DATE SIGNED <b>10/5/71</b>		23C. PHYSICIAN'S NAME (Type) <b>CESAR VILUSTRAD INTERN</b> DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
<b>Burial</b>		<b>10-8-71</b>		<b>Westminster Cem</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Buryge Funeral Home Baltimore Md</b> ADDRESS <b>1212 North Howard St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 9437	
7-210 71 9437		BIRTH NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
MARY ELIZABETH FISHPAW		October 5 1971 3:45 A.M.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE	
00 2211 West Rogers Avenue				Maryland	
5. SEX		6. RACE		C. CITY OR TOWN	
Female		White		Baltimore	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS?	
8. DATE OF BIRTH		9. AGE (In years last birthday)		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Feb 15 1886		85			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		E. STREET AND NUMBER	
Housewife		-		2211 West Rogers Avenue	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Maryland		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Sylvester Small		Emma Jane Smith			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		216 05 2215 D		The Wesley Home	
ADDRESS		same			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		Cerebral Hemorrhage	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) Hypertensive Cardiovascular Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		22. I certify that (I) (this hospital) attended the deceased from		22. I certify that (I) (this hospital) attended the deceased from	
that (I) (we) last saw the deceased alive on		that (I) (we) last saw the deceased alive on		that (I) (we) last saw the deceased alive on	
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED			
John W. Barnaby		8 October 1971			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. John W. Barnaby		1652 East Belvedere Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8 Oct 71		Jessops Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT		24F. NAME OF REGISTRAR	
York Road, Balto Co. Maryland		OCT 12 1971		Robert E. Geller, R.D.	
25A. FUNERAL DIRECTOR		25B. ADDRESS			
Burgess Funeral Home, Baltimore, Maryland					

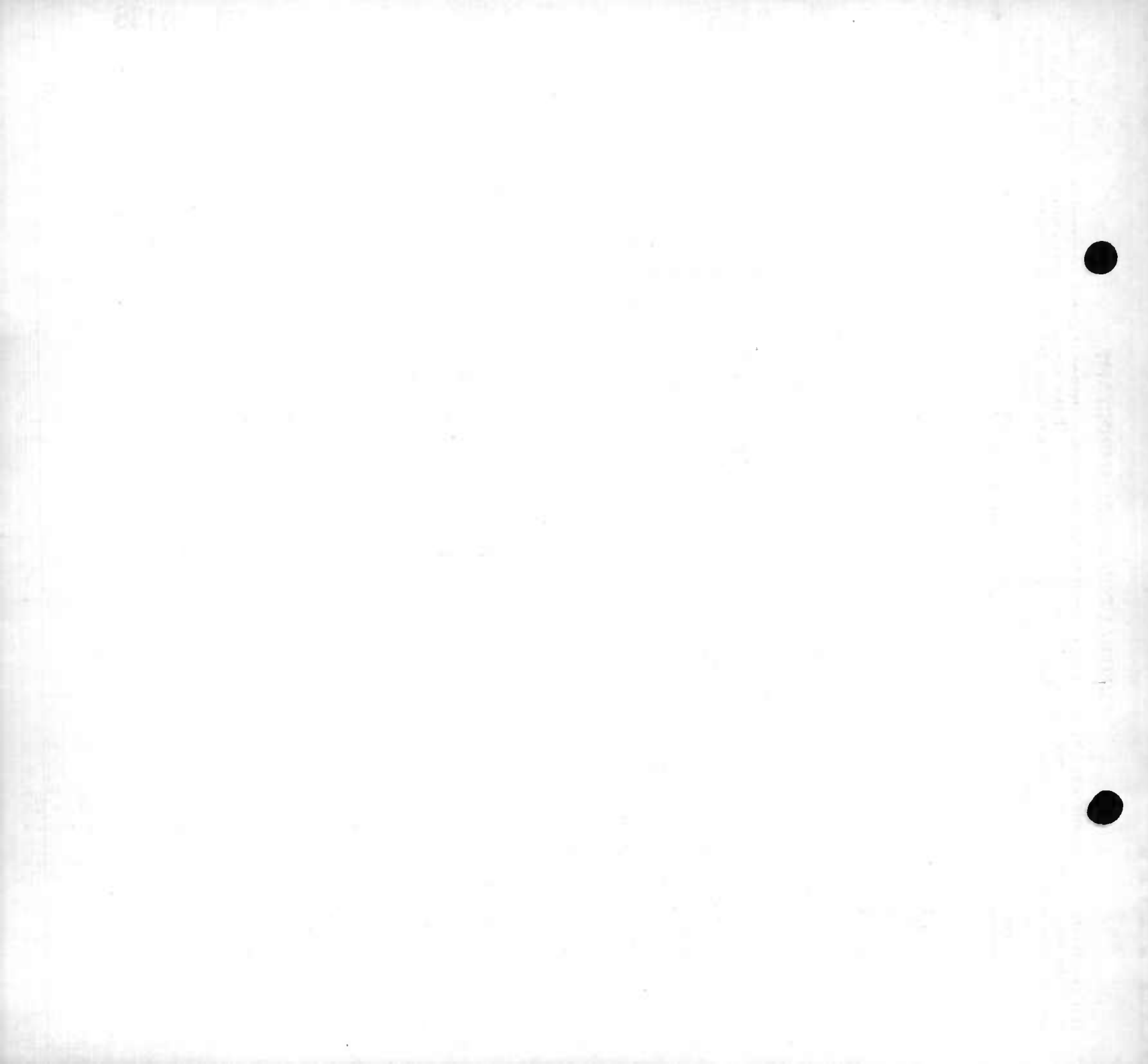
6/8/58 Adm.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

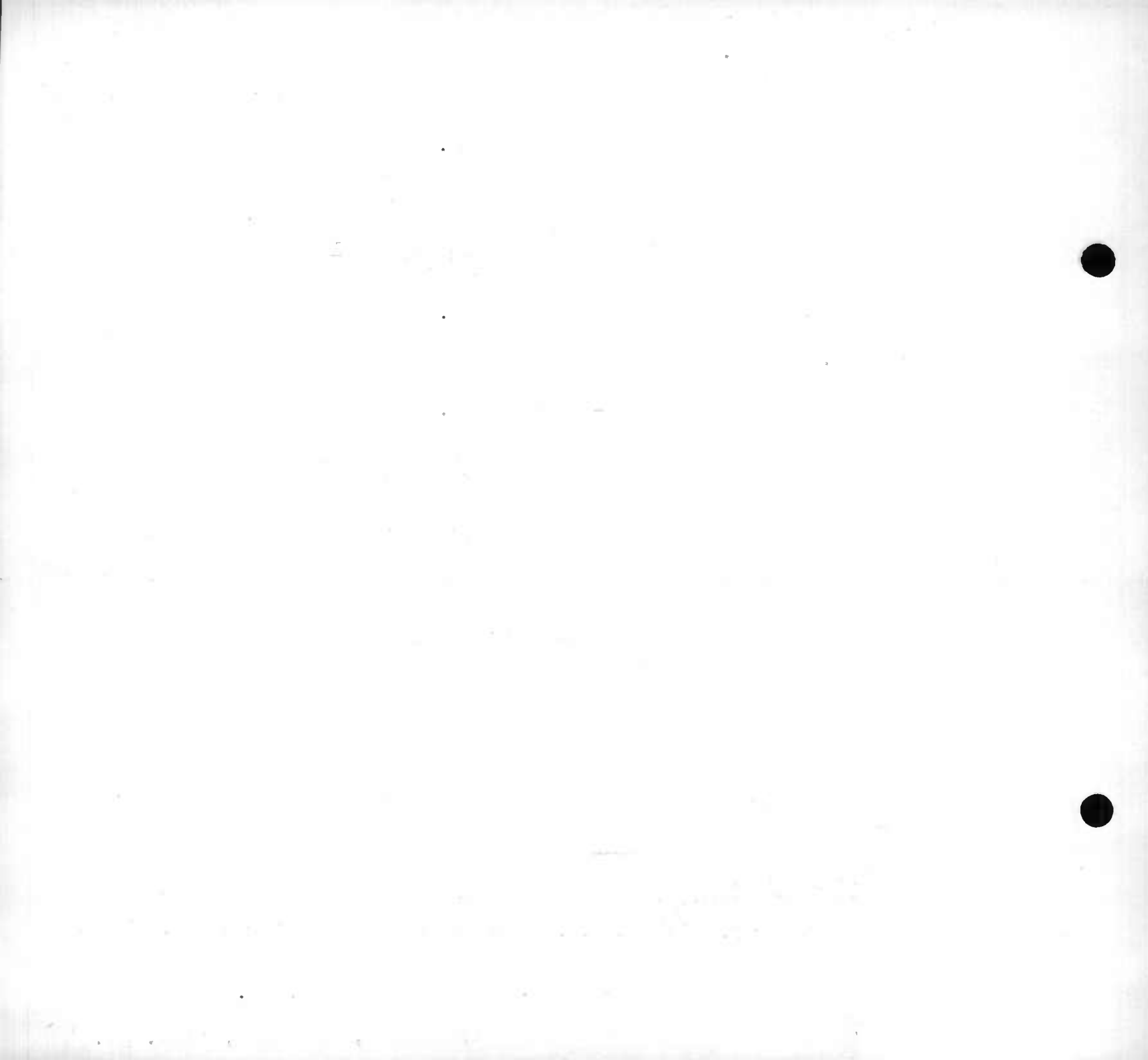
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>71 9438</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>R-25271 9438</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROZANKOWSKI, Joseph</b>		2. DATE AND HOUR OF DEATH <b>10-10-1971 1.25 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Memorial Hospital</b>			(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) A. STATE <b>MARYLAND</b> B. COUNTY <b>2733</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5008 GRINDON AV.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>02-03-91</b>	9. AGE (In years lost birthday) <b>74</b>	10. UNDER 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>UNKNOWN. Julian</b>		
14. MOTHER'S MAIDEN NAME <b>UNKNOWN.</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>212-10-2045</b>			17. INFORMANT <b>MR. LEON ROZANKOWSKI</b> <b>UNKNOWN, 1606 THE TROY AVE</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>162.1 I</b>			CAUSE OF DEATH <b>LUNG Shock.</b>		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Radiation PNEUMONIA</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Coronaries of the lungs.</b> (C) <b>Congestive Heart Failure.</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10-7-1971</b> to <b>10-10-1971</b> that (I) (we) last saw the deceased alive on <b>10-10-1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Carlos A. Battilana MD.</b>			23B. DATE SIGNED <b>10-10-71</b>		23C. PHYSICIAN'S NAME (Type) <b>Carlos A. Battilana MD.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24B. DATE <b>10-13-71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH</b>
24D. LOCATION (City, town, or county) (State) <b>BALTO MD 21214</b>			25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		
25B. NAME OF REGISTRAR <b>Robert E. Fisher MD.</b>			25C. FUNERAL DIRECTOR <b>WILLIAM J. RUCK, INC</b>		
25D. ADDRESS <b>BALTO MD</b>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

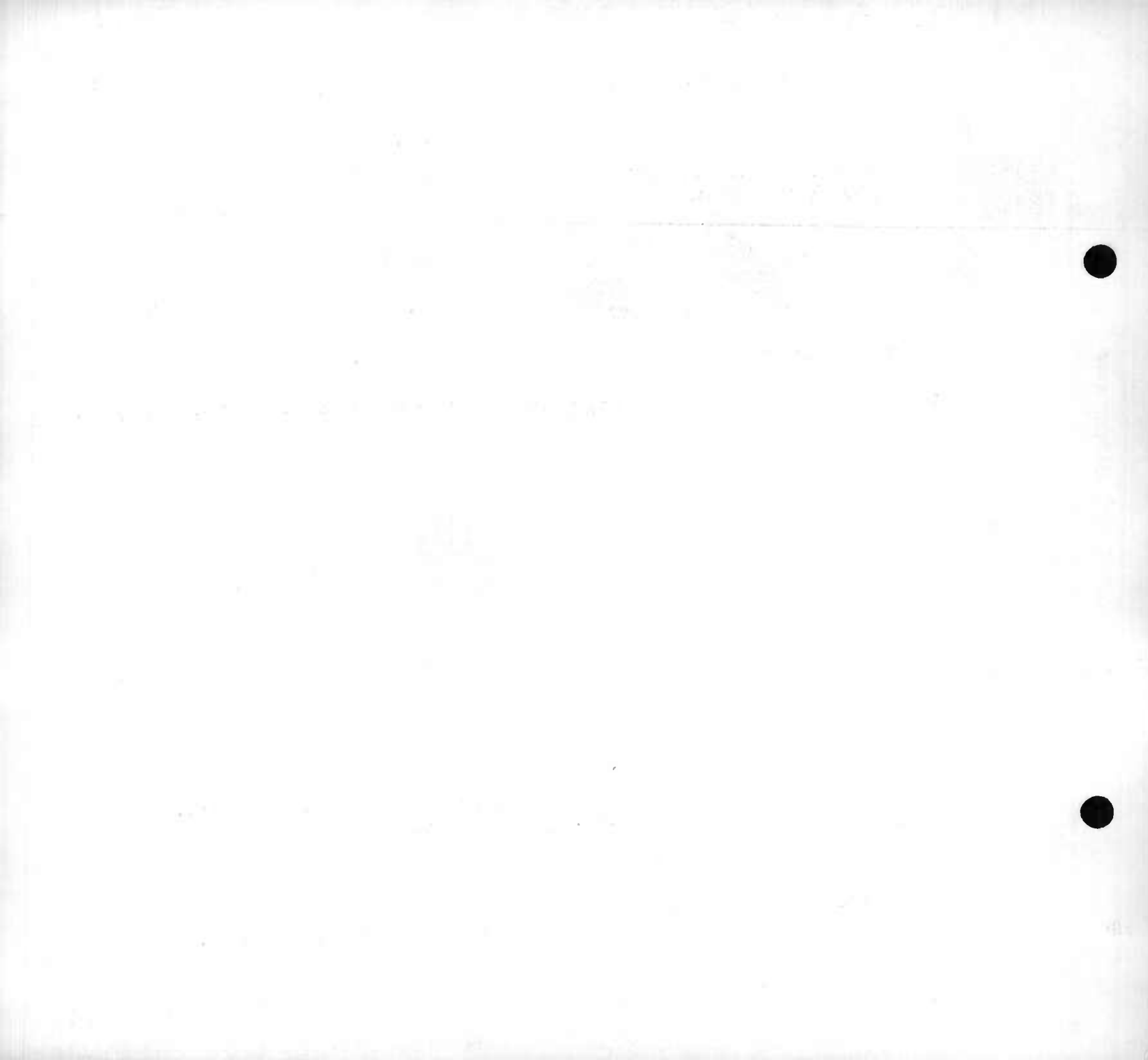
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 9439</b>	
M-633 71 9439				CERTIFICATE OF DEATH	
BIRTH NO. <b>71 9439</b>		F.			
1. NAME OF DECEASED (Type or Print) <b>WILLIAM MEREDITH</b>			2. DATE AND HOUR OF DEATH <b>10/8/71 11:50 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Gould Convalesarium</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2706</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>2607 Evergreen Ave.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/8/31-7-81</b>	9. AGE (In years last birthday) <b>90</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer Old Bay Line</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>William F. Meredith</b>		
14. MOTHER'S MAIDEN NAME <b>Alice Holland</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>217-14-3711</b>			17. INFORMANT <b>Mrs. Christine Meredith same</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>260X1 + 250.9</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			(B) <b>Arteriosclerosis</b> (C) <b>Coronary</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes; Ch. Congestive Heart Failure; Ch. Brain Syndrome</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>7/29/71</b> to <b>10/8/71</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>10/8/71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Albert B. Bradley</b>			23B. DATE SIGNED <b>10/8/71</b>		23C. PHYSICIAN'S NAME (Type) <b>ALBERT B. BRADLEY, M.D.</b>
23D. ADDRESS <b>4900 BELAIR ROAD BALTO., MD. 21206</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/11/71</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cem.</b>	
24D. LOCATION <b>Balto. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>E. J. Ruck, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc, Balto. Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

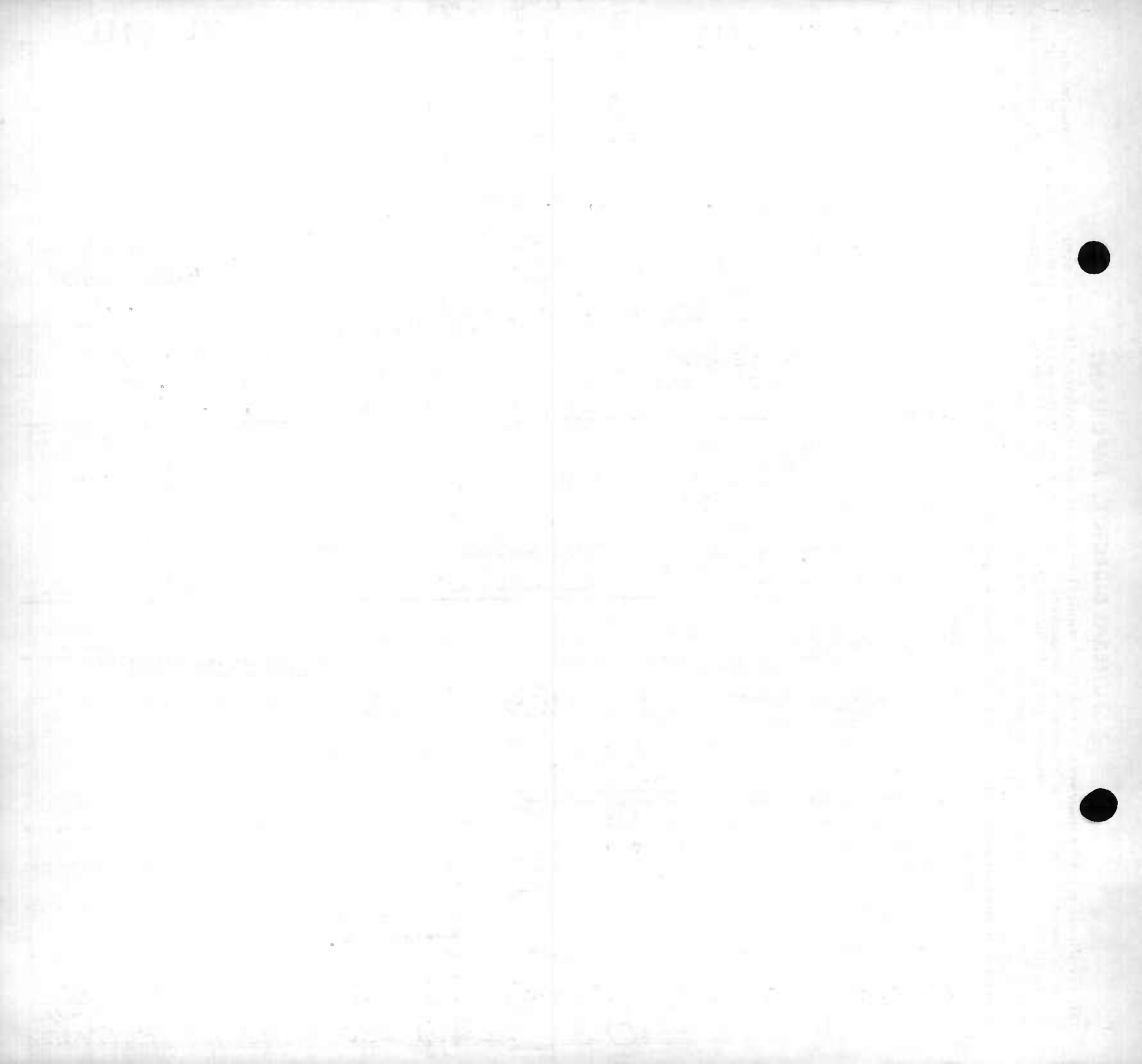
J-250 71 9440		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 9440	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Robert Asbury Jackson		Oct. 6, 1971 7:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		V43	
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 23 3100 Wyman Parkway		A. STATE Va.		B. COUNTY	
5. SEX M		6. RACE Col		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9/26/24		9. AGE (in years last birthday) 47		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AB seaman		10B. KIND OF BUSINESS OR INDUSTRY Seafarer		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Jackson		14. MOTHER'S MAIDEN NAME Blanche E. Peyton	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 229-20-0888		17. INFORMANT Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 144X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebral anoxia DUE TO, OR AS A CONSEQUENCE OF: Seizures - Brain metastasis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Squamous Cell Ca of Floor of Mouth		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 29 19 71 to Oct. 6 19 71 that (I) (we) last saw the deceased alive on Oct. 6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel R. Herndon		23B. DATE SIGNED 10-6-71		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS US PHS Hospital, Balto, Md.		23E. DEGREE		23F. DEGREE	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 10-9-71		24C. NAME OF CEMETERY or CREMATORY Sharp Hill Cemetery	
24D. LOCATION (City, town, or county) (State) King George Va.		24E. DATE REC'D BY HEALTH DEPT. OCT 12 1971		24F. NAME OF REGISTRAR R. S. E. [unclear]	
24G. FUNERAL DIRECTOR [unclear]		24H. ADDRESS [unclear]		24I. ADDRESS [unclear]	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <span style="float: right;">W-160 71 9441</span>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">71 9441</span>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Peter Weber				10-10-71 10 40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
31 Baltimore City Hospital				Maryland		2646	
4940 Eastern Ave. Baltimore, Md. 21224				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				F. STREET AND NUMBER			
6718 Youngtown Ave				6718 Youngtown Ave			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
male		white		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		6-6-98	
9. AGE (in years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
73		PENNSA RAILROAD		Maryland		U.S.A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John WEBER				Constance NOVAK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
N/A				215-08-4047		4940 Eastern Ave. ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
250171				cardiac arrest		12 hours	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		12 hours	
ANTECEDENT CAUSES				(B) arteriosclerotic cardiovascular disease -			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) diabetes mellitus			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 10-9-1971 to 10-10-1971 that (I) (we) last saw the deceased alive on 10-10-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
John C. Ruckdeschel, MD				10-10-71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
John C. Ruckdeschel, MD				Baltimore City Hospital			
4940 Eastern Ave.				St. Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		10-14-71		Holy ROSARY CEM. DUNDALK, BALTO, MD			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 12 1971		Robert E. Jantz, MD		John W. Weber & Sons Inc.		401 S. CHESTER	





**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>71 9442</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>S-160 71 9442</b></span> <span><b>BIRTH NO.</b></span> </div>					
<b>1. NAME OF DECEASED</b> (Type or Print) <b>JAMES W. SHAFFER</b>			<b>2. DATE AND HOUR OF DEATH</b> <b>10-4-71 1:25 A.M.</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>33 The Johns Hopkins Hospital</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution; residence before admission) A. STATE <b>Delaware</b> B. COUNTY <b>Newcastle</b>		
<b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>33 The Johns Hopkins Hospital</b>			<b>C. CITY OR TOWN</b> <b>Newark</b>		<b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			<b>E. STREET AND NUMBER</b> <b>105 Amherst Drive</b>		
<b>5. SEX</b> Male	<b>6. RACE</b> Cau.	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 2/28/04	<b>9. AGE</b> (In years last birthday) <b>67</b>	<b>10. UNDER 1 Yr.</b> Months Days <b>11. UNDER 24 Hrs.</b> Hours Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Vice Pres. &amp; Gen Mgr. Del Rel Inc.</b>			<b>11. BIRTHPLACE</b> (State or foreign country) <b>Butler, Pennsylvania</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
<b>13. FATHER'S NAME</b> <b>Harry Shaffer</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Jane Logan</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2		<b>16. SOCIAL SECURITY NO.</b> 174-09-4351		<b>17. INFORMANT</b> Mildred A. Shaeffer	
				<b>ADDRESS</b> Same	
<b>18. CAUSE OF DEATH</b>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>410.9 I</b>			<b>CARDIOGENIC SHOCK</b>		
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b>		
			<b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> 6 DAYS		
			<b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b> 6 years		
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <b>BRONCHIECTASIS</b>					
<b>19A. DATE OF OPERATION</b> 2 NONE		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY? (Yes or No)</b> Yes	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from 9-29-71 to 10-4-71 that (I) (we) last saw the deceased alive on 10-4-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>Benjamin L. Portnoy M.D.</b>				<b>23B. DATE SIGNED</b> 10-4-71	
<b>23C. PHYSICIAN'S NAME (Type)</b> Benjamin L. Portnoy, M.D.		<b>23D. ADDRESS</b> Johns Hopkins Hospital			
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> Burial		<b>24B. DATE</b> 10-7-71		<b>24C. NAME of CEMETERY or CREMATORY</b> North Cemetery	
				<b>24D. LOCATION</b> (City, town, or county) (State) Butler, Pennsylvania	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> OCT 12 1971		<b>25B. NAME OF REGISTRAR</b> Robert E. Fisher, R.D.		<b>25C. FUNERAL DIRECTOR</b> Frank J. Warwick	
				<b>ADDRESS</b> Newark, Dela.	

5110



S-350 9443

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9443

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Willie L. Stone		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> 10 8 1971 Month Day Year		Hour 2:50 PM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital		3. DATE PRONOUNCED DEAD 10 8 1971 Month Day Year		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2003		C. CITY OR TOWN Baltimore	
6. SEX male		7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 5/5/30		10. AGE (In years lost birthday) 41		11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leo P. Stone		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Bessie		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1955	
17. SOCIAL SECURITY NO. 240-40-439		18. INFORMANT Mrs. M.J. Stone		19. ADDRESS 1905 Wilhelm St.		20. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic cardio-vascular disease (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
21. DATE OF OPERATION 2		22. CONDITION FOR WHICH OPERATION WAS PERFORMED		23. AUTOPSY? (Yes or No) yes		24. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		27. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
29. HOW DID INJURY OCCUR?		30. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 10/9/71		31. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial		32. 24B. DATE 10/4/71	
33. 24C. NAME OF CEMETERY or CREMATORY Mt. Zion		34. 24D. LOCATION (City, town, or county) (State) Morgan Co. W. Va.		35. 25A. DATE REC'D BY HEALTH DEPT. OCT 12 1971		36. 25B. NAME OF REGISTRAR W. E. E. E. E.	
37. 25C. FUNERAL DIRECTOR H. J. Schwartz, Inc.		38. ADDRESS		39. VS 151-REV. 7/1/68			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 71 9444	
4-20071 9444		BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <u>Hess, Duane</u> <span style="float: right;">DUANE</span>				2. DATE AND HOUR OF DEATH <u>October 11, 1971</u> <span style="float: right;">8:43 A.M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Florida</u> B. COUNTY <u>V08</u> C. CITY OR TOWN <u>Stuart</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>Po Box # 2183</u>			
5. SEX <u>Male</u>	6. RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/22/49</u>	9. AGE (in years last birthday) <u>22</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Owayne Royal Hess, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Marjorie Betts</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Carney Funeral Home Inc.</u>		ADDRESS <u>La Grange Ind.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.) <u>Staph Sepsis</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute Myelo-Monocytic Leukemia 1 month</u>				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 9</u> 19 <u>71</u> to <u>October 11</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>October 11</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Evelyn Hills MD</u>				23B. DATE SIGNED <u>10/11/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Evelyn Hills MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/14</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>La Grange Ind.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Tabor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Carney Funeral Home Inc.</u>		ADDRESS	



<p style="font-size: 24pt; margin: 0;">71 9445</p> <p style="font-size: 18pt; margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 24pt; margin: 0;">MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p>		<p style="font-size: 24pt; margin: 0;">71 9445</p> <p style="font-size: 18pt; margin: 0;">REG. NO.</p>											
<p>BIRTH NO. <span style="font-size: 24pt; margin-left: 10px;">W-420</span></p>													
<p>1. NAME OF DECEASED (Type or Print)</p> <p style="text-align: center; font-size: 18pt;">Earl E. Welsh, Jr.</p>		<p>2. DATE OF DEATH</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>Known <input checked="" type="checkbox"/></td> <td>Month</td> <td>Day</td> <td>Year</td> <td>Hour</td> </tr> <tr> <td>Estimated <input type="checkbox"/></td> <td>10</td> <td>11</td> <td>71</td> <td>4:15 P. M.</td> </tr> </table>		Known <input checked="" type="checkbox"/>	Month	Day	Year	Hour	Estimated <input type="checkbox"/>	10	11	71	4:15 P. M.
Known <input checked="" type="checkbox"/>	Month	Day	Year	Hour									
Estimated <input type="checkbox"/>	10	11	71	4:15 P. M.									
<p>4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p style="font-size: 24pt; margin-left: 10px;">40 St. Agnes Hospital</p>		<p>3. DATE PRONOUNCED DEAD</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>Month</td> <td>Day</td> <td>Year</td> <td>Hour</td> </tr> <tr> <td>10</td> <td>11</td> <td>71</td> <td>4:15 P. M.</td> </tr> </table>		Month	Day	Year	Hour	10	11	71	4:15 P. M.		
Month	Day	Year	Hour										
10	11	71	4:15 P. M.										
<p>5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE <span style="font-size: 18pt; margin-left: 10px;">Maryland</span></p> <p>B. COUNTY <span style="font-size: 18pt; margin-left: 10px;">2551</span></p>													
<p>6. SEX</p> <p style="font-size: 18pt;">Male</p>	<p>7. RACE</p> <p style="font-size: 18pt;">White</p>	<p>8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>C. CITY OR TOWN</p> <p style="font-size: 18pt;">Baltimore</p>										
<p>9. DATE OF BIRTH</p> <p style="font-size: 18pt;">3/29/21</p>		<p>10. AGE (In years, last birthday)</p> <p style="font-size: 18pt;">50</p>	<p>11. BIRTHPLACE (State or foreign country)</p> <p style="font-size: 18pt;">Baltimore, Md.</p>										
<p>12. CITIZEN OF WHAT COUNTRY?</p> <p style="font-size: 18pt;">USA</p>		<p>13. FATHER'S NAME</p> <p style="font-size: 18pt;">Unknown</p>											
<p>14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p style="font-size: 18pt;">Westinghouse</p>		<p>14B. KIND OF BUSINESS OR INDUSTRY</p> <p style="font-size: 18pt;">Unknown</p>											
<p>15. MOTHER'S MAIDEN NAME</p> <p style="font-size: 18pt;">Unknown</p>													
<p>16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>17. SOCIAL SECURITY NO.</p> <p style="font-size: 18pt;">214-18-0462</p>	<p>18. INFORMANT</p> <p style="font-size: 18pt;">Earl E. Welsh, Jr.</p>										
<p>19. CAUSE OF DEATH</p> <p style="font-size: 24pt; margin-left: 10px;">412.4 I</p>		<p>ADDRESS <span style="font-size: 18pt; margin-left: 10px;">Balto Md. 4223</span></p>											
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="font-size: 18pt; margin-left: 10px;">Arteriosclerotic cardiovascular disease</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p>											
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p>		<p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p>											
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>		<p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p>											
<p>20A. DATE OF OPERATION</p>		<p>20B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>											
<p>21. AUTOPSY? (Yes or No)</p> <p style="font-size: 18pt; text-align: center;">No</p>													
<p>22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>											
<p>22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>													
<p>22D. TIME OF INJURY (APPROX.)</p> <p>(Month) (Day) (Year) (Hour)</p>		<p>22E. INJURY OCCURRED</p> <p>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>											
<p>22F. HOW DID INJURY OCCUR?</p>													
<p>23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>													
<p>ACTUAL SIGNATURE EXAMINER'S NAME (Type)</p> <p style="font-size: 18pt; margin-left: 10px;">Werner U. Spitz, M.D.</p>		<p>Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/></p>											
<p>DATE SIGNED</p> <p style="font-size: 18pt; margin-left: 10px;">10-12-71</p>													
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p style="font-size: 18pt;">Burial</p>		<p>24B. DATE</p> <p style="font-size: 18pt;">10/15/71</p>											
<p>24C. NAME OF CEMETERY OR CREMATORY</p> <p style="font-size: 18pt;">Balto Natl Cem.</p>		<p>24D. LOCATION (City, town, or county) (State)</p> <p style="font-size: 18pt;">Balto, Md.</p>											
<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p style="font-size: 18pt;">OCT 12 1971</p>		<p>25B. NAME OF REGISTRAR</p> <p style="font-size: 18pt;">Robert E. Gabel, M.D.</p>											
<p>25C. FUNERAL DIRECTOR</p> <p style="font-size: 18pt;">George L. Schwartz, Inc.</p>		<p>ADDRESS</p>											



ESTD 1890

ACADEMIC RECORD

MAINTAINANCE



# FUNERAL DIRECTOR: IMPORTANT


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 9446	
BIRTH NO. L-50071 9446		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Walter Robert Lunn			2. DATE AND HOUR OF DEATH October 3, 1971 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore Gen. Hosp.			A. STATE Maryland B. COUNTY A.H. 5200		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 5919 Belle Grove Road		
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1910	9. AGE (in years last birthday) 61	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			11. BIRTHPLACE (State or foreign country) South Carolina		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Robert Lunn			14. MOTHER'S MAIDEN NAME Lelia McClendon		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-10-1519		
			17. INFORMANT Mrs. Sarah A. Lunn 5919 Belle Grove Road ADDRESS		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 4 1969 to 9-1 1971 that (I) (we) last saw the deceased alive on 9-1 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eugene Schmitz DEGREE				23B. DATE SIGNED 10-6-71	
23C. PHYSICIAN'S NAME (Type) EUGENE SCHMITZ, M.D. DEGREE				23D. ADDRESS 3904 S. Hanover St. Balt. Md. 21225	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-7-71		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION Baltimore, Maryland		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. OCT 12 1971		25B. NAME OF REGISTRAR Robert E. Barber, Jr.		25C. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1727 N. Monroe Street	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">71 9447</span>	
BIRTH NO. <span style="float: right;">Y-520 71 9447</span>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>YOUNG JAMES L.</b>			2. DATE AND HOUR OF DEATH <b>10/5/71. 4:30 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1503</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>2405 WEST NORTH AVE</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-23-32</b>	9. AGE (In years last birthday) <b>39</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Harry Young</b>			14. MOTHER'S MAIDEN NAME <b>Rosa Bailey</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-30-8972</b>	17. INFORMANT ADDRESS <b>Mrs. Lavina Young 2705 W. North Ave.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>SEVERE TOXAEMIA BECAUSE OF PROGRESSIVE &amp; MASSIVE PERITONITIS</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>PERFORATION OF SIGMOID COLON</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>10/4/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>MASSIVE PERITONITIS</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (it) (this hospital) attended the deceased from <b>9/25/71</b> 19 <b>71</b> to <b>10/5</b> 19 <b>71</b> that (it) (we) last saw the deceased alive on <b>10/5</b> 19 <b>71</b> and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <b>SEVIN LWIN</b>			23D. ADDRESS <b>LUTHERAN HOSPITAL OF MARYLAND.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-9-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Arlington S. Phillips 1727 N. Monroe St.</b>	

1st April 1900

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>G-450</b>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>421539448</b>	
1. NAME OF DECEASED (Type or Print) <b>MORRIS, WILLIAM</b>			2. DATE AND HOUR OF DEATH <b>10-10-71 10:15 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>University Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1512</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University Hospital</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>2454 KEYWORTH AVE 21215</b>		
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 19, 1950</b>	9. AGE (In years last birthday) <b>21</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTROPLATER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>KOPPERS CO.</b>		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>	
13. FATHER'S NAME <b>RUSCOE A. GILLIAM</b>			12. CITIZEN OF WHAT COUNTRY? <b>US</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>246-84-9261</b>		17. INFORMANT <b>CAROLYN GILLIAM</b>
			ADDRESS <b>SOME</b>		
18. CAUSE OF DEATH <b>135-X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>VENTRIC. FIBRILL.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs</b>
			(B) <b>SARCOID MYOCARDITIS</b> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>9-16</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-16</b> 19 <b>71</b> to <b>10-10</b> 19 <b>71</b> that (I) (we) last saw the deceased alive on <b>10-10</b> 19 <b>71</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>William H. Buckelew MD</b>				23B. DATE SIGNED <b>10-10-71</b>	
23C. PHYSICIAN'S NAME (Type) <b>William H. Buckelew MD</b>				23D. ADDRESS <b>Arlington S. Phillips 1727 N. Monroe Street</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>10-14-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Indian Wood</b>	
24D. LOCATION (City, town, or county) (State) <b>Windsor, North Carolina</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD</b>		25C. FUNERAL DIRECTOR <b>Arlington S. Phillips 1727 N. Monroe Street</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9449</u>	
BIRTH NO. <u>R-350 71 9449</u>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>Rhodes, Gus A.</b>		2. DATE AND HOUR OF DEATH <b>10-8-71 5:45 a.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>39</b> <b>Provident Hospital, Inc.</b> <b>2600 Liberty Heights Ave.</b> <b>Baltimore, Maryland 21215</b>		A. STATE <b>Maryland</b> B. COUNTY <b>2733</b>			
		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>2408 Montabello Terrace</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-5-96</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Texas</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>0 50-09-2677</b>		17. INFORMANT ADDRESS <b>Lucille P. Rhodes/Wife 2408 Montabello Terr.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Failure</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Chronic bronchitis, poss. Ca. lung</b> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-29</b> <b>71</b> to <b>10-8</b> <b>71</b> that (I) (we) last saw the deceased alive on <b>10-8</b> <b>71</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>B. VANASIN M.D.</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>B. Vanasin M.D.</b>		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-12-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Arlington S. Phillips 1727 N. Monroe Street</b>	

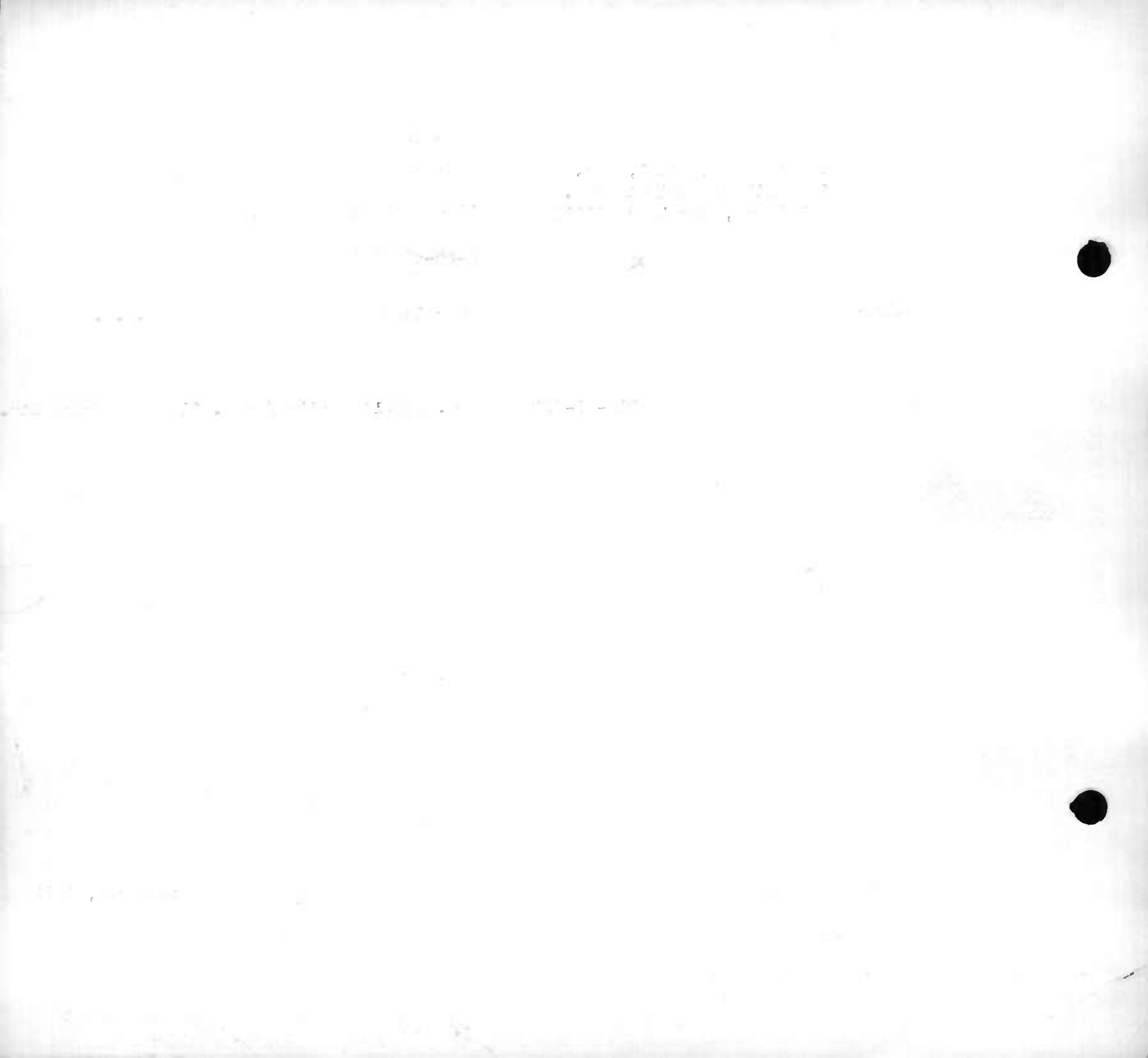




# FUNERAL DIRECTOR: IMPORTANT

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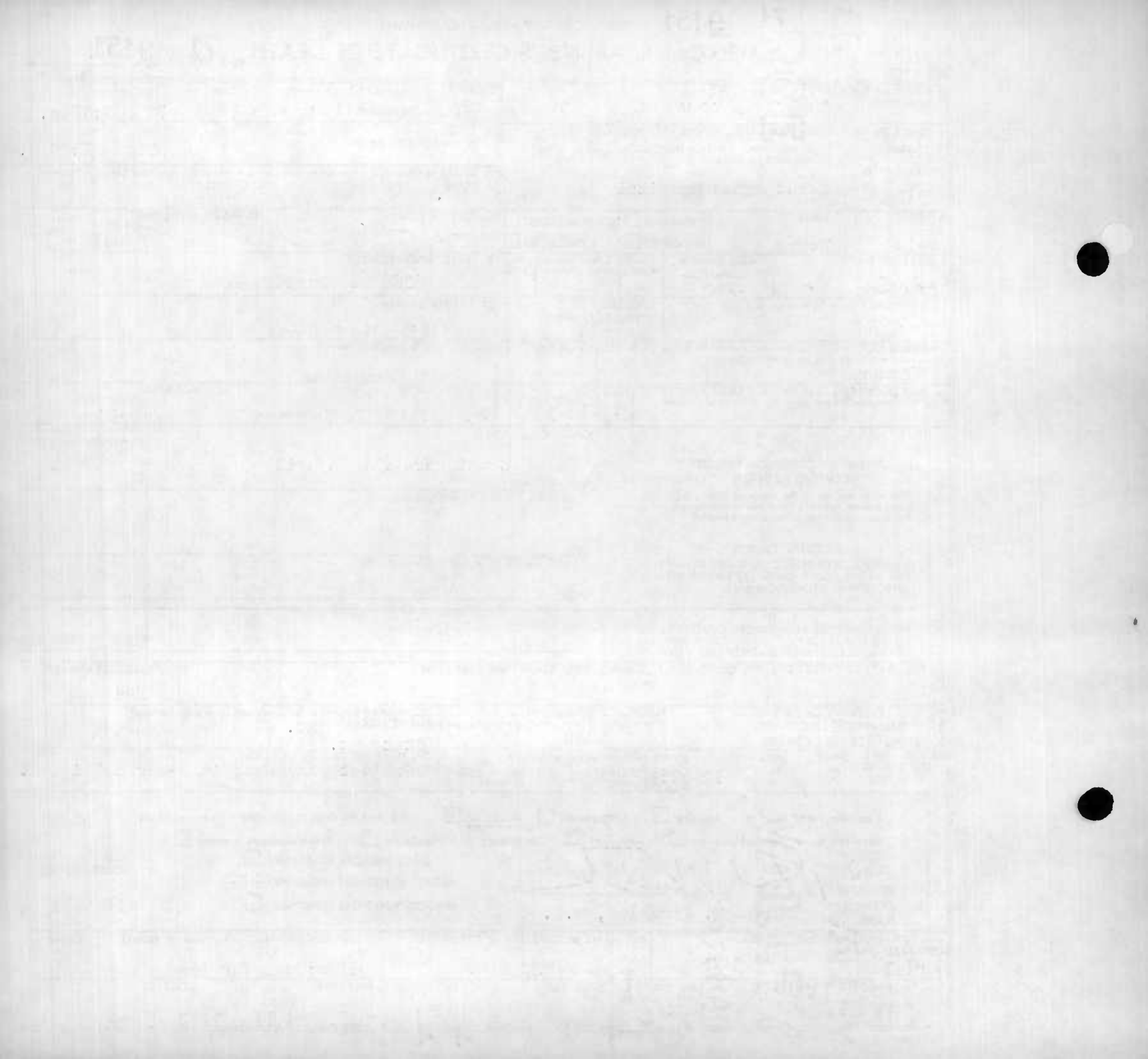
B-62071 9450		BALTIMORE CITY HEALTH DEPARTMENT		71 9450	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>GONZIE BROOKS</b>			2. DATE AND HOUR OF DEATH <b>Oct 5, 71 8:05 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1547</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital, Inc. 2600 Liberty Heights Ave. Baltimore, Maryland 21215</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>2106 Ashburton Street</b>		
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/22/98</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Thomas Brooks</b>			14. MOTHER'S MAIDEN NAME <b>Maggie Gray</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>219-03-6539</b>		17. INFORMANT <b>Mrs. Novella Bailey/Daug. 2106 Ashburton Str.</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>CA Pancreas - metastases</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>CA Pancreas - metastases</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>CA Pancreas - metastases</b>			(B) DUE TO, OR AS A CONSEQUENCE OF:		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>CA Pancreas - metastases</b>			(C) DUE TO, OR AS A CONSEQUENCE OF:		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>CA Pancreas - metastases</b>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Arteriosclerosis</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 22 1971</b> to <b>Oct 5 1971</b> that (I) (we) last saw the deceased alive on <b>Oct 5 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Boon Vanasin</b>				23B. DATE SIGNED <b>October 5, 1971</b>	
23C. PHYSICIAN'S NAME (Type) <b>BOON VANASIN</b>				23D. ADDRESS <b>Provident Hosp. Balti, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-8-71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	
24D. LOCATION (City, town, or county) (State) <b>Balti, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>			
25B. NAME OF REGISTRAR <b>Robert E. Barber, M.D.</b>		25C. FUNERAL DIRECTOR <b>1727 N. Morgan St.</b>			



S-160 71 9451 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 71 9451  
 REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Russell Albert Sparrow</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>10 6 71 7:25 a. m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 Saint Agnes Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 6 71 7:25 a. m.</b>	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>4/21/26</b>		10. AGE (In years lost birthday) <b>45</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		15. MOTHER'S MAIDEN NAME <b>Ruth Blackstone</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>217-30-3076</b>	
18. INFORMANT <b>Mr. William T. Sparrow</b>		ADDRESS <b>6489 Meadowridge Road</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Craniocerebral injuries</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A)-			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>ROAD</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Rt. #1 &amp; Meadowridge Road (State Rt. #103)</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>9 26 71 12:15 a. m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject passenger in 3-car collision.</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10/6/71</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-9-71</b>	
24C. NAME OF CEMETERY or CREMATORY <b>St. Stephens Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Elkridge, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>Robert L. Gabley, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Arlington S. Phillips</b>		ADDRESS <b>1727 N. Monroe Street</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

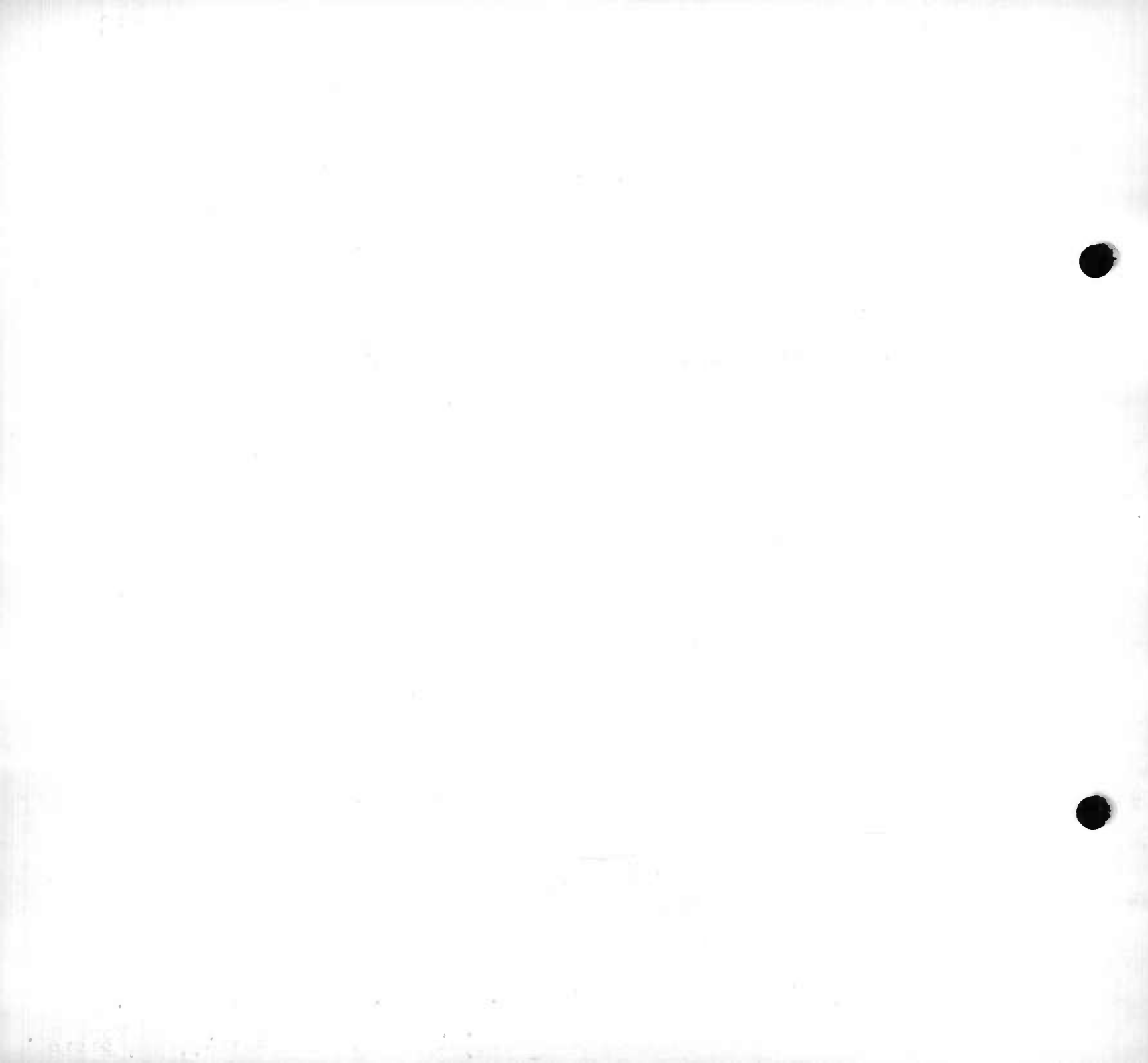
BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>9452</u>	
BIRTH NO. <u>7-630</u> <u>71</u> <u>9452</u>					
1. NAME OF DECEASED (Type or Print) <u>Charlotte Manning Ford</u>		2. DATE AND HOUR OF DEATH <u>10-9-71</u> <u>6 a.</u> <u>M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>101 W. Monument St. Apt. 12K</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1102</u>			
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>101 W. Monument St.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-15-1898</u>	9. AGE (In years last birthday) <u>73</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Catonsville, Md.</u>	
13. FATHER'S NAME <u>William Ebeling</u>		14. MOTHER'S MAIDEN NAME <u>Flora Albert</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Edwin Manning</u>	
				ADDRESS <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>342X1</u> <u>Bronchopneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Parkinson's Disease; Intestine block</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Bronchopneumonia</u> (B) <u>Parkinson's Disease; Intestine block</u> (C) <u>years</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>ca. 10 d.</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from <u>years</u> 19 <u>Oct 9</u> 19 <u>71</u> that (I) <u>was</u> last saw the deceased alive on <u>Oct 8</u> 19 <u>71</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We) (did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Louis P. Hamberger, Jr.</u>				23B. DATE SIGNED <u>10/11/71</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<u>Dr. Louis P. Hamberger, Jr.</u>		<u>1001 St. Paul St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<u>Burial</u>		<u>10-12-71</u>		<u>Loudon Park Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<u>OCT 12 1971</u>		<u>Robert E. Jenkins, Jr.</u>		<u>H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9453</u>	
H-453 71 9453				CERTIFICATE OF DEATH	
BIRTH NO. <u>71 9453</u>		1. NAME OF DECEASED (Type or Print) <u>BESSIE C. HOLLAND</u>		2. DATE AND HOUR OF DEATH <u>10/11/71</u> <u>3:50 A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>21212</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5627 Purdue Ave</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>06/23/89</u>	9. AGE (In years last birthday) <u>82</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>LEWIS A. Todd</u>		14. MOTHER'S MAIDEN NAME <u>CARRIE WILSON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-05-4910A</u>		17. INFORMANT <u>LEWIS A. CRAIG</u> ADDRESS <u>(SAME)</u>	
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>None</u>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u>					
19A. DATE OF OPERATION <u>10/11/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>No</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>No</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>10/11/71</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/8</u> 19 <u>71</u> to <u>10/11</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10/11/71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>10-11-71</u>		23C. PHYSICIAN'S NAME (Type) <u>C. GAKUBA</u>	
23D. ADDRESS <u>827, Linden Ave. MARYLAND GEN. HOSP.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>10/14/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Moreland Mem. Park Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1971</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto., Md. 21212</u>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

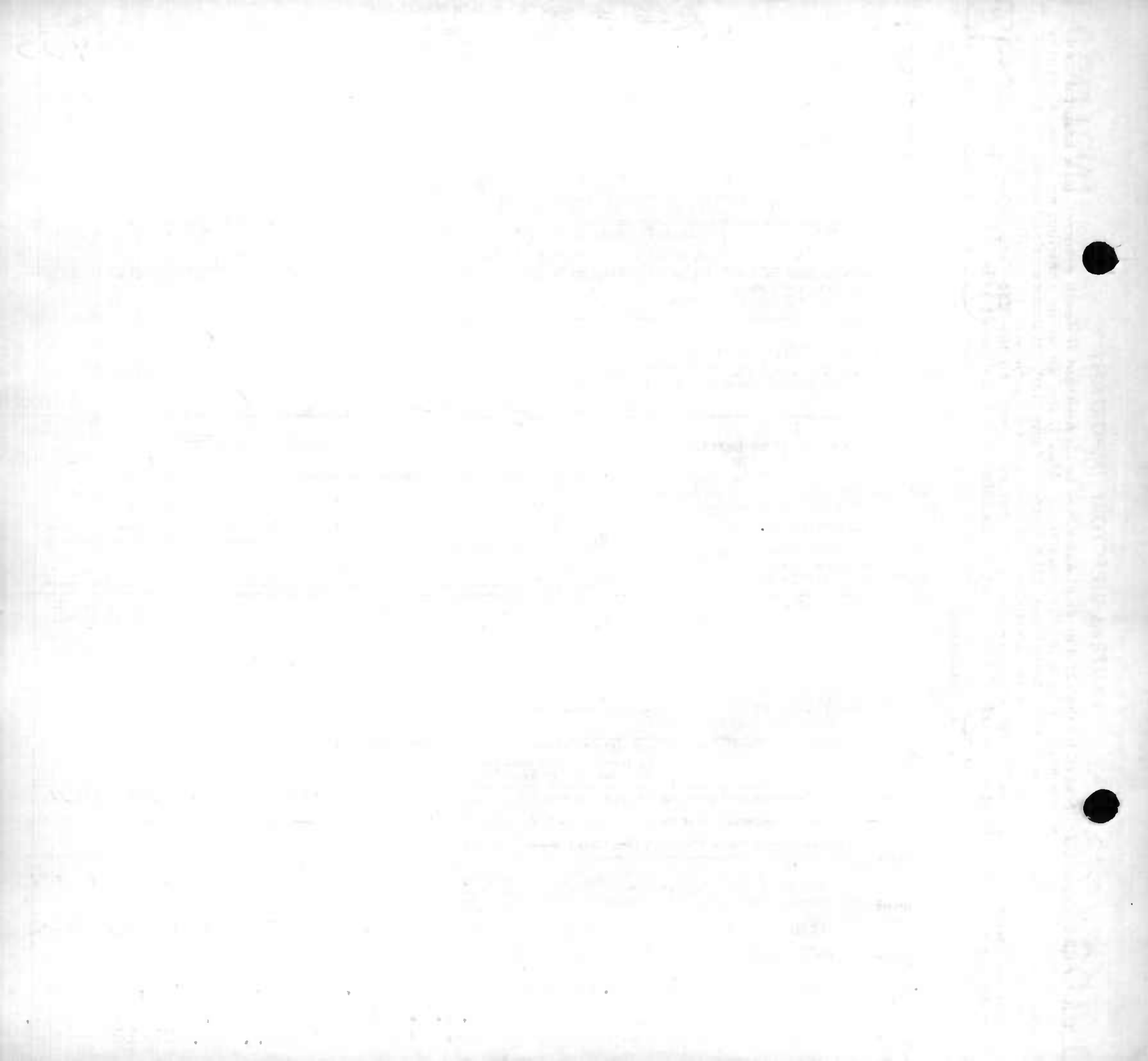
BIRTH NO. <u>J-523 71 9454</u>				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 9454</u>	
1. NAME OF DECEASED (Type or Print) <u>JOHNSTON, NELLIE R.</u>				2. DATE AND HOUR OF DEATH <u>OCT. 10 1971 1:20 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>MD. Gen Hosp. Balto. and.</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO</u>			
				C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1702 Park Ave. 21217.</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7. 2. 1910</u>	9. AGE (in years last birthday) <u>61.</u>	If Under 1 Tr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COUNSELOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>PERSONNEL</u>		11. BIRTHPLACE (State or foreign country) <u>ALBANY, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES F. RIELY</u>				14. MOTHER'S MAIDEN NAME <u>LOUELLA BRIGGS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>		16. SOCIAL SECURITY NO. <u>212-18-536</u>		17. INFORMANT <u>NORMAN M. JOHNSTON (SAME)</u>			
18. <u>1538 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>CARCINOMA of COLON</u> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cancer Colon</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cancer Colon</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MOS</u> <u>10/10/71</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>9-15-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Colon Cancer</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> <u>NO</u> If yes, specify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9-15-71</u> to <u>10-10-71</u> and that (I) (we) lost the deceased alive on <u>10-10-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>H. S. RANGANATHAN MD</u>				23B. DATE SIGNED <u>Oct 10, 1971</u>			
23C. PHYSICIAN'S NAME (Type) <u>H. S. RANGANATHAN MD</u>		23D. ADDRESS <u>MD. Gen Hosp. Balto. and.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>10-13-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenmount</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 12 1971</u>		25B. NAME OF REGISTRAR <u>MD. Gen Hosp. Balto. and.</u>		25C. FUNERAL DIRECTOR <u>J. W. Jenkins &amp; Sons Co</u> ADDRESS <u>14905 York Road Balto., Md. 21212</u>			



# FUNERAL DIRECTOR: IMPORTANT

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CITY HEALTH DEPARTMENT				REG. NO. <u>71-9455</u>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> <small>(Type or Print)</small> <u>Galloway Alexander K</u>		<b>CERTIFICATE OF DEATH</b> <b>2. DATE AND HOUR OF DEATH</b> <u>October 11, 1971</u> <u>7 30</u> <u>P</u> <u>M.</u>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <small>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</small> <u>Union Memorial Hospital</u> <u>Baltimore, Md - 21218</u>		<b>4. USUAL RESIDENCE</b> <small>(Where deceased lived, if institution residence before admission)</small> <b>A. STATE</b> <u>Md.</u> <b>B. COUNTY</b> <u>1201</u> <b>C. CITY OR TOWN</b> <u>Balto.</u> <b>D. INSIDE CITY LIMITS?</b> <b>E. STREET AND NUMBER</b> <u>Canterbury Road 3811</u>		
<b>5. SEX</b> <u>M.</u>	<b>6. RACE</b> <u>W.</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10/1/85</u>	<b>9. AGE</b> <small>(in years last birthday)</small> <u>86</u>
<b>10A. USUAL OCCUPATION</b> <small>(Give kind of work done during most of working life, even if retired)</small> <u>GEN. SUPT. MOTOR POWER</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>B &amp; O RR</u>		<b>11. BIRTHPLACE</b> <small>(State or foreign country)</small> <u>ST. THOMAS, ONTARIO</u>
<b>13. FATHER'S NAME</b> <u>Robert Galloway</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Harriett Alexander</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>A-622752</u>		<b>17. INFORMANT</b> <u>MRS Lee B. Galloway</u>
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> <b>ANTECEDENT CAUSES</b> <b>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</b> <u>① Acute &amp; chronic urinary infection</u> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <u>② Diabetes Mellitus</u> <u>③ Nephrosclerosis</u>		<b>CAUSE OF DEATH</b> <u>CVA.</u> <b>(A) IMMEDIATE CAUSE</b> <u>DUE TO, OR AS A CONSEQUENCE OF:</u> <u>Cerebro-Vascular Disease</u> <u>ASVD, Diabetes mellitus</u> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <u>Hypertensive Cardiovascular Disease</u> <b>(C)</b> <u>5 yrs ±</u> <u>5 yrs ±</u>		
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <u>No.</u>		<b>20A. AUTOPSY?</b> <small>(Yes or No)</small> <u>No.</u>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> <small>(Notify medical examiner)</small> <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> <small>(e.g., in or about home, farm, factory, street, office bldg., etc.)</small> <u>INJURY OCCUR?</u>		<b>21C. WHERE DID INJURY OCCUR?</b> <small>(If in Baltimore City, give exact location)</small>
<b>21D. TIME OF INJURY</b> <small>(Month) (Day) (Year) (Hour)</small> <b>(APPROX.)</b>		<b>21E. INJURY OCCURRED</b> <b>While At Work</b> <input type="checkbox"/> <b>Not While At Work</b> <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>19 4 12</u> <b>to</b> <u>OCTOBER 11, 1971</u> <b>that (I) (we) last saw the deceased alive on</b> <u>OCT. 11, 1971</u> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <u>Robert W. Garis, M.D.</u>		<b>Attending Phys.</b> <input checked="" type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input checked="" type="checkbox"/>		<b>23B. DATE SIGNED</b> <u>OCTOBER 11, 1971</u>
<b>23C. PHYSICIAN'S NAME</b> <small>(Type)</small> <u>ROBERT W. GARIS, M.D.</u>		<b>23D. ADDRESS</b> <u>12 E. EAGER ST., BALTIMORE, MD. 21202</u>		
<b>24A. BURIAL CREMATION, REMOVAL</b> <small>(Specify)</small> <u>Rem. Entombment</u>		<b>24B. DATE</b> <u>10/15/71</u>		<b>24C. NAME of CEMETERY or CREMATORY</b> <u>St. Thomas</u>
<b>24D. LOCATION</b> <small>(City, town, or county)</small> <u>St. Thomas, Ontario, Canada</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>OCT 12 1971</u>		
<b>25B. NAME OF REGISTRAR</b> <u>Robt. J. Taylor</u>		<b>25C. FUNERAL DIRECTOR</b> <u>H. W. Jenkins &amp; Sons Co.</u>		
<b>25D. ADDRESS</b> <u>Balto., Md. 21212</u>		<b>25E. ADDRESS</b> <u>4905 York Rd.</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

7-652 71 9456		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 71 9456	
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT			
1. NAME OF DECEASED (Type or Print) <b>LENA A. FRANCISCVS</b>				2. DATE AND HOUR OF DEATH <b>10. 11. 71 7.20 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore General Hospital.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>21222 BALTO 5300</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2620 Yorkway - Dundalk</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-22-89</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETAIL STORE</b>		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel A. Green (Dec)</b>				14. MOTHER'S MAIDEN NAME <b>Nan Green (Dec)</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>204-01-3128A</b>		17. INFORMANT <b>Mrs PAULINE F. BAKER, 2620 YORKWAY 21222</b>			
18. <b>427.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Restrictive Lung Disease</b> <b>Tachycardia &amp; P.V.C.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>N.A.</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N.A.</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10. 10. 1971</b> to <b>10. 11. 1971</b> that (I) (we) last saw the deceased alive on <b>12:15 AM 10. 11. 1971</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>10. 11. 71</b>	
23C. PHYSICIAN'S NAME (Type) <b>D. S. SAWHNEY</b>				23D. ADDRESS <b>South Baltimore General Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL/REMOVAL</b>		24B. DATE <b>10 OCT. 71</b>		24C. NAME OF CEMETERY or CREMATORY <b>WESTMINSTER CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>CARLISLE, PA.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>U.S. FUNERAL HOMES, BALTO, MD. 21206</b>		ADDRESS	



ERRORS HEREON CORRECTED BY FUNERAL HOME.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-535 71 9457		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 9457	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>GARRETT A. DUNTON</b>			
2. DATE AND HOUR OF DEATH <b>10-11-1971 11 30 A.M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Church Home and Hospital</b> <b>100 N. Broadway St.</b> <b>Balti MD. 21231</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>DUNDALK</b> D. INSIDE CITY LIMITS? <b>NO</b> E. STREET AND NUMBER <b>2803 Dungen Court 21222</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-14-1910</b>	9. AGE (in years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WEIGHT MASTER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL MFR.</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A. American</b>	
13. FATHER'S NAME <b>AUBREY DUNTON</b>				14. MOTHER'S MAIDEN NAME <b>EDITH MESSICK</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-07-1947</b>		17. INFORMANT <b>A. Soud. Nove MD. Church Home Hospital</b>		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute Myocardial Infarction</b> <b>Coronary artery disease</b> <b>Generalized arteriosclerosis</b> <b>Diabetes mellitus</b> <b>Brain syndrome</b> <b>Bone marrow depression</b> <b>Chronic kidney amputation of leg due to Gangrene of lower limbs</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b> <b>many years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>Sept 14, 1971</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Gangrene Leg</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indify medical examiner) <b>none</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>none</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>none</b>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>none</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>none</b>					
22. I certify that (I) (this hospital) attended the deceased from <b>08-25-71</b> 1971 to <b>10-11-</b> 1971 that (I) (we) lost saw the deceased alive on <b>10-11-</b> 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>W. B. Maniago, M.D.</b>				23B. DATE SIGNED <b>10/11/71</b>		23C. PHYSICIAN'S NAME (Type) <b>WILMA B. MANIAGO, M.D.</b>	
23D. ADDRESS <b>CHH</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			
24B. DATE <b>10/14/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>LORRAINE PARK</b>		24D. LOCATION (City, town, or county) (State) <b>WOODLAWN, MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1971</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>W. B. Maniago</b>		25D. ADDRESS <b>W. B. Maniago, D.D., Baltimore, Md.</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9458</span>	
B-632 71 9458 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">(Bratkowska) BRATKOWSKI, JOSEPHINE</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">10-7-71 7:45 P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">UNION MEMORIAL HOSPITAL 44</span>			A. STATE & COUNTY <span style="font-size: 1.2em;">MARYLAND - BALTIMORE 833</span>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">2232 KENTUCKY AVENUE</span>		
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">11-18-87</span>	9. AGE (in years last birthday) <span style="font-size: 1.2em;">75 84</span>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">HOUSEWIFE</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">—</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">POLAND</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">UNITED STATE</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">UNKNOWN</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">UNKNOWN</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-12-0196</span>			17. INFORMANT <span style="font-size: 1.2em;">Mary Stachurski (dghtr) same address</span>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <span style="font-size: 1.2em;">2. SEVERE STARVATION, DEHYDRATION</span>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">1. SEVERE HYPOPOTAISEMIA AND HYPOGLYCEMIA</span>		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">1. SUPP. GRAM NEG. SEPSIS</span>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? Yes <input checked="" type="checkbox"/> or No <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">10-7-71</span> to <span style="font-size: 1.2em;">10-7-71</span> and that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">10-7-71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">J. P. Allen M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">10/7-71</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">J. P. MIKUS</span>				23D. ADDRESS <span style="font-size: 1.2em;">UNION MEMORIAL HOSPITAL</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">10/11/71</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Holy Rosary Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Balto. Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">OCT 13 1971</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fisher, R.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21215</span>			

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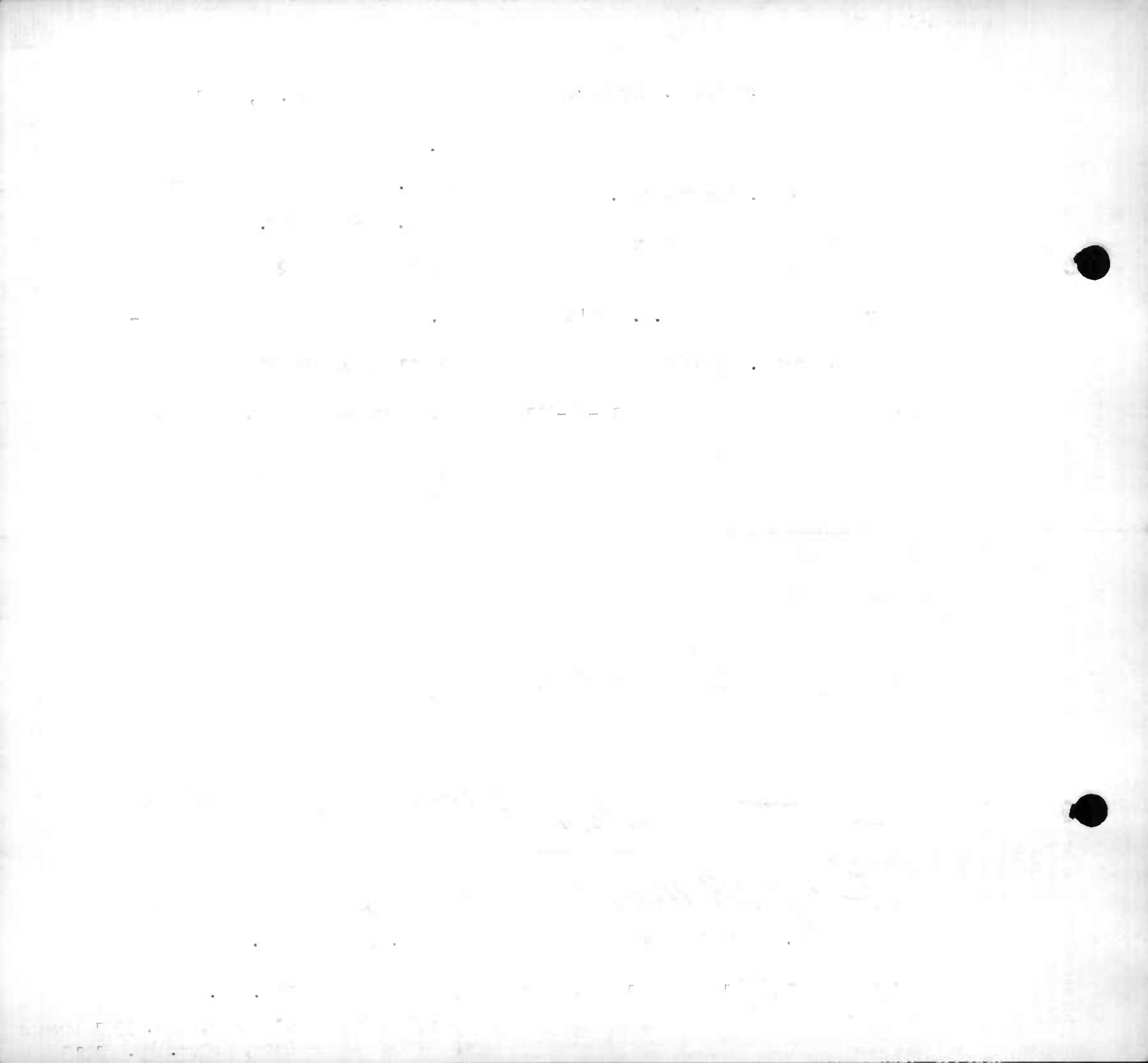
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9458</u>	
BIRTH NO. <u>B-652 71 9458</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Lorraine C. Barranco</u>			2. DATE AND HOUR OF DEATH <u>Oct. 6, 1971</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>829 N. Luzerne Ave.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>702</u>		
			C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>829 N. Luzerne Ave.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/5/29</u>	9. AGE (in years last birthday) <u>42</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>-</u>
13. FATHER'S NAME <u>Harry V. Panuska</u>			14. MOTHER'S MAIDEN NAME <u>Estelle Kaczubinski</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-48-3316</u>	17. INFORMANT <u>Leo Barranco (husband) same address</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Hodgkins' Disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>1971 (June)</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>lymphoid condition</u> 20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1945</u>
22. I certify that (I) (this hospital) attended the deceased from <u>October</u> 19 <u>70</u> to <u>10/6/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10/6/71</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Benjamin Moses</u>			23B. DATE SIGNED <u>10/8/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Benjamin Moses</u>
23D. ADDRESS <u>448 N. Luzerne Ave.</u>			23E. DEGREE <u>DEGREE</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>10/9/71</u>	24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 13 1971</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	25C. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc.</u>	25D. ADDRESS <u>3331 Brehms Lane, Balto. Md. 21214</u>		



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.5em;">71 9460</span>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">PHILIP LIBERATORE</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">10/2/71 3:15PM</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">33 JOHNS HOPKINS HOSPITAL</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">2642</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">BALTIMORE</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">4356 PARKSIDE DRIVE</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">MALE</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">WHITE</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <del>UNMARRIED</del> <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">12/12/09</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">61</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Sprayer</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Marina Electronics</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">W. Va.</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.</span>		<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">SAMUEL LIBERATORE</span>			
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">ROSA D'ONOFRIO</span>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>			
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">046 09 4499</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Emma</span> <span style="font-size: 1.2em;">Nancy Liberatore (wife) same address</span>			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Sepsis</span>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">250.9 1-148.1</span>			
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">diabetes + post-op fistulae</span>		<b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <span style="font-size: 1.2em;">carcinoma of the neck</span>			
<b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b> <span style="font-size: 1.2em;">craniiform tumor</span>		<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>			
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">9/7/71</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">Ca PYLORIC SINUS</span>		<b>20A. AUTOPSY? (Yes or No)</b> <span style="font-size: 1.2em;">No</span>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">Oct. 1</span> <b>19</b> <span style="font-size: 1.2em;">71</span> <b>to</b> <span style="font-size: 1.2em;">Oct 7</span> <b>19</b> <span style="font-size: 1.2em;">71</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">Oct. 7</span> <b>19</b> <span style="font-size: 1.2em;">71</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Pamela P. Scott M.D.</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">10/2/71</span>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <span style="font-size: 1.2em;">DR. P. SCOTT</span>		<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></span>			
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">10/11/71</span>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Holy Redeemer Cemetery</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Balto. Md.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">OCT 13 1971</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Talley, M.D.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213</span>			

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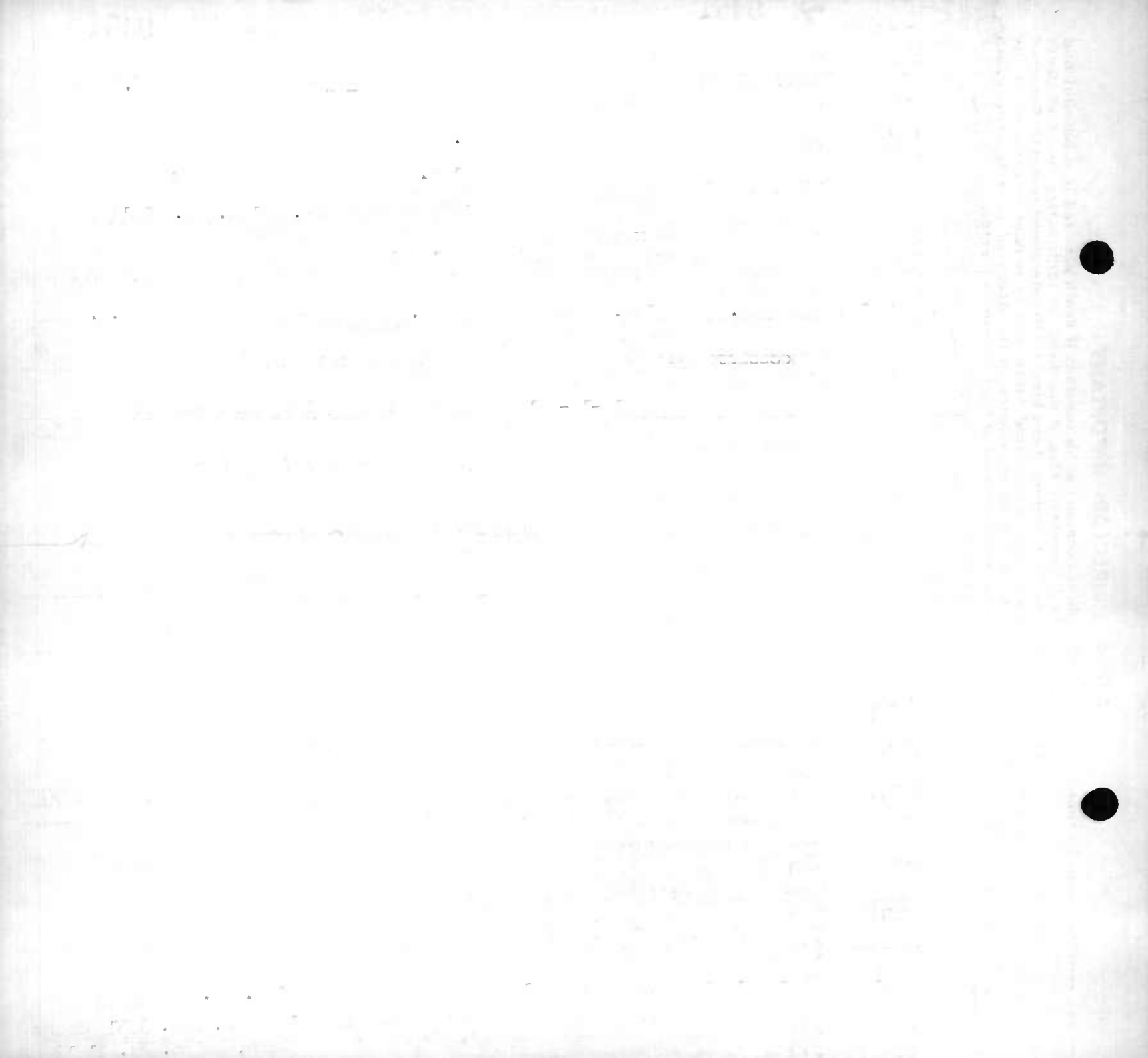
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9461</u>	
BIRTH NO. <u>S-100</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>WILLIAM SCHaub</u>			2. DATE AND HOUR OF DEATH <u>10-9-71</u> <u>5.00 AM</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37 MERCY HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2643</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3778 Bonview Ave. Balto. Md. 21213</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/17/03</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired elevator oper.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. City</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Andrew Schaub</u>			14. MOTHER'S MAIDEN NAME <u>Hannah Connaughton</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-12-0619</u>	17. INFORMANT <u>Marie Schaub (wife) same address</u>		
18. <u>436.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>ANoxia - due to CVA.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arterio sclerosis.</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>10/21/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 4</u> 19 <u>71</u> to <u>Oct 9</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Oct 8</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph B Agnello</u>			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>Joseph B Agnello</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>10/21/71</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>			25A. DATE REC'D BY HEALTH DEPT. <u>OCT 13 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Schaub</u>			25C. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213</u>		

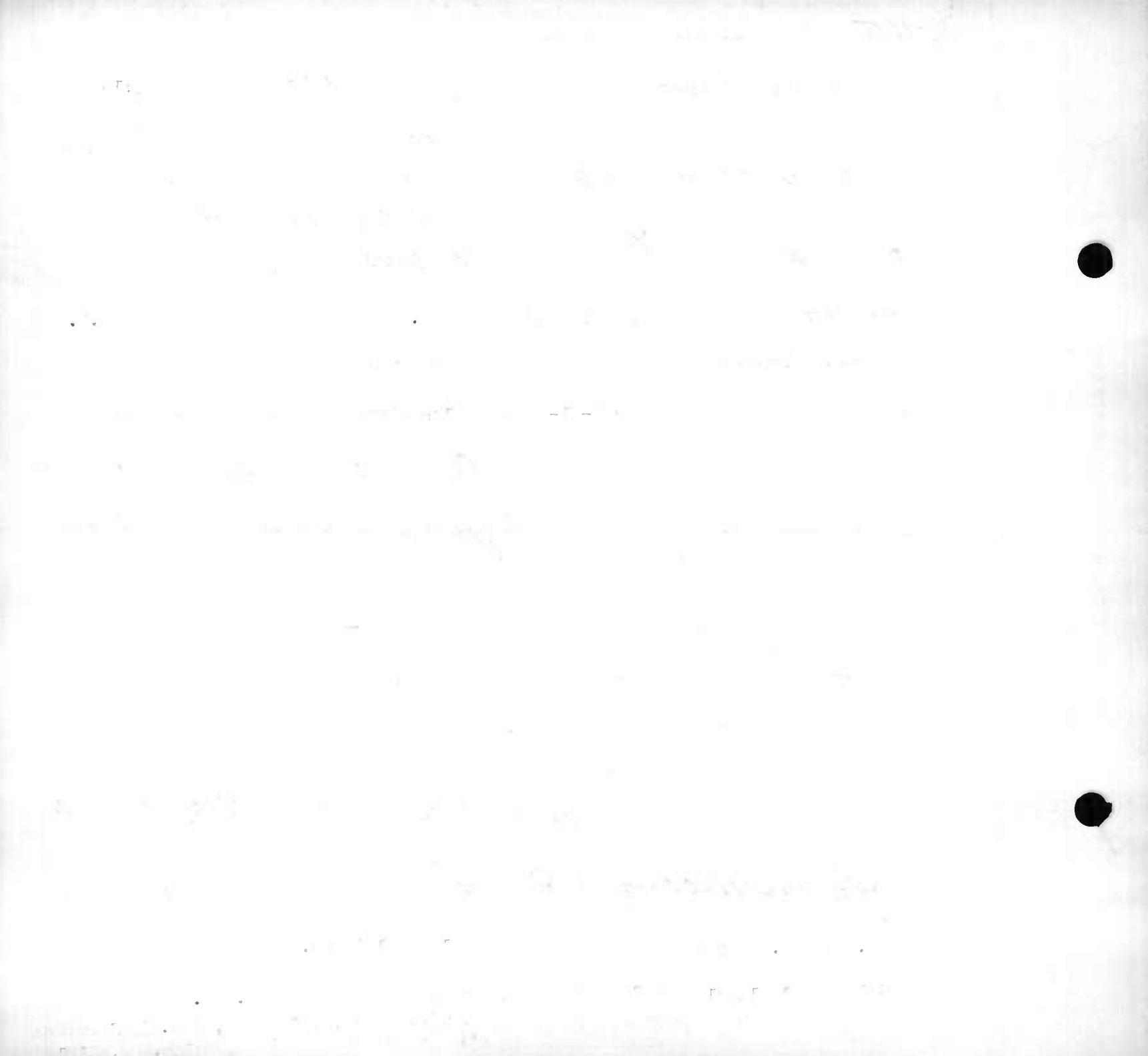




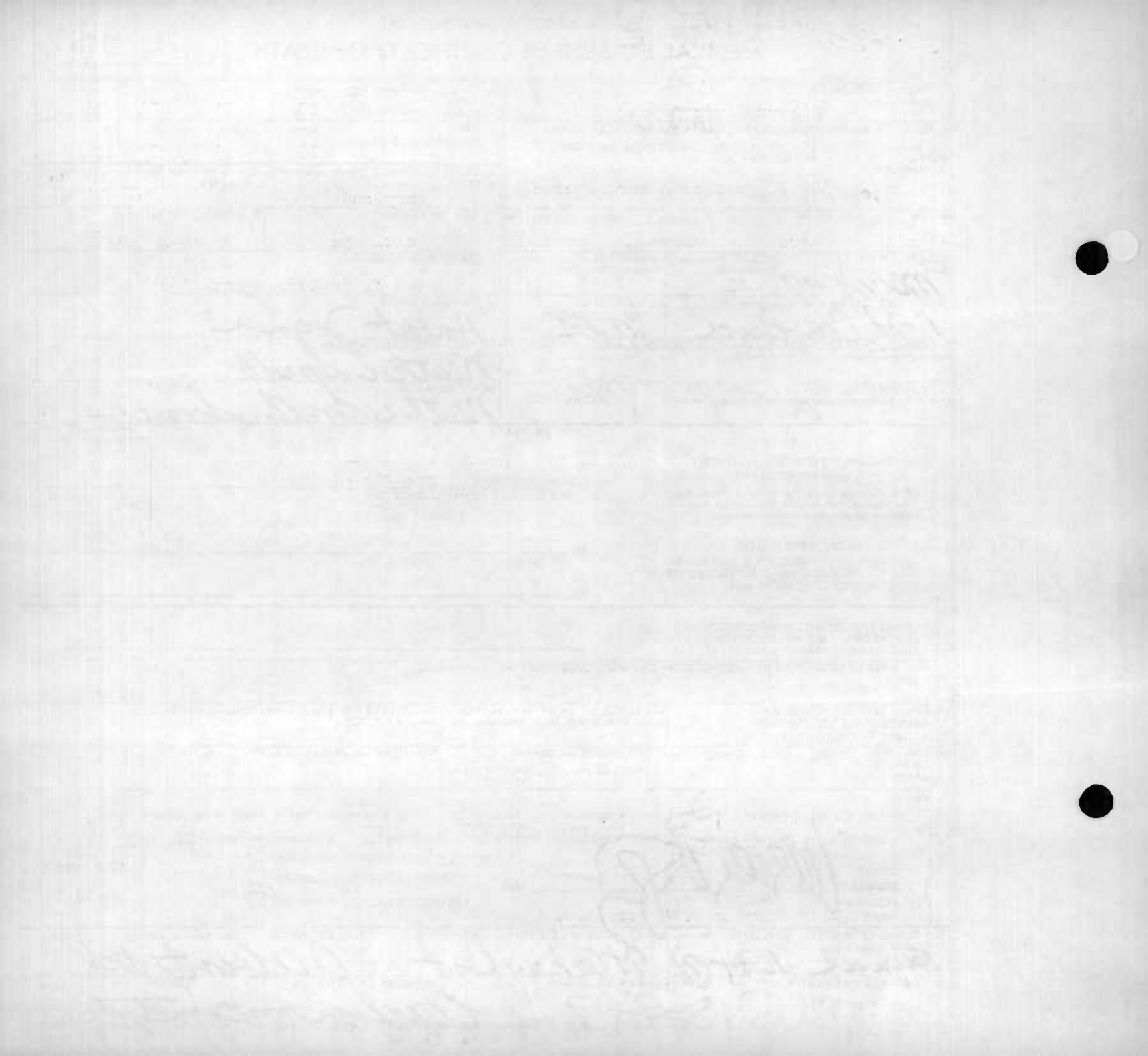
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">71 9462</span>	
L-165 <span style="font-size: 1.5em;">71 9462</span>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">John August Livermon</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">10/9/71</span> <span style="float: right;">3:15 AM</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">00 2005 BELAIR RD</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.5em;">Md</span> B. COUNTY <span style="font-size: 1.5em;">841</span>		
			C. CITY OR TOWN <span style="font-size: 1.5em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.5em;">2005 Belair Rd</span>		
5. SEX <span style="font-size: 1.5em;">M</span>	6. RACE <span style="font-size: 1.5em;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.5em;">3-3-02</span>	9. AGE (In years last birthday) <span style="font-size: 1.5em;">69</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">chauffeur</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">American Brewery</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Md.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">John Livermon</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">unknown</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">216-07-0760</span>		17. INFORMANT <span style="font-size: 1.2em;">Helen Livermon (wife) same address</span>	
18. <span style="font-size: 1.5em;">410.9 I</span> CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.5em;">Coronary thrombosis</span>					<span style="font-size: 1.5em;">1 minute</span>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.5em;">Hypertensive CKD</span>					<span style="font-size: 1.5em;">4 yrs</span>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">no</span>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">Aug.</span> 19 <span style="font-size: 1.2em;">71</span> to <span style="font-size: 1.2em;">Oct 9</span> 19 <span style="font-size: 1.2em;">71</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">10-5</span> 19 <span style="font-size: 1.2em;">71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Dr. Duer J. Moores</span>					23B. DATE SIGNED <span style="font-size: 1.5em;">10-9-71</span>
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Dr. Duer J. Moores</span>			23D. ADDRESS <span style="font-size: 1.2em;">3105 Belair Rd.</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">10/12/71</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Holy Redeemer Cemetery</span>	
24D. LOCATION <span style="font-size: 1.2em;">Balto. Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">OCT 13 1971</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert J. Talbot</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">Schimunek Funeral Homes, Inc.</span>		25D. ADDRESS <span style="font-size: 1.5em;">3331 Brehms Lane, Balto. Md.</span>	



J-560 71 9463		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		71 9463	
BIRTH NO.		REG. NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
Robert Lewis Joyner		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour		FULL NAME OF HOSPITAL OR INSTITUTION	
		10 11 71 11:30 P.M.		Month Day Year Hour		408 N. Patterson Park Avenue	
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
Male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		A. STATE B. COUNTY	
						Maryland 603	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
May 4 47		23		North Carolina		U.S.A.	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
Hubert Joyner				Neather Smith		No	
17. SOCIAL SECURITY NO.		18. INFORMANT		19. CAUSE OF DEATH		20. DATE OF OPERATION	
		Neather Smith				21. AUTOPSY? (Yes or No)	
						Yes	
22. TIME (Month) (Day) (Year) (Hour)		23. INJURY OCCURRED		24. NAME OF CEMETERY or CREMATORY		25. DATE REC'D BY HEALTH DEPT.	
22D. OF INJURY (APPROX.)		22E. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		24C. NAME OF CEMETERY or CREMATORY		25A. DATE REC'D BY HEALTH DEPT.	
				24D. LOCATION (City, town, or county) (State)		25B. NAME OF REGISTRAR	
				All County Md		Robert E. Fisher, M.D.	
22F. HOW DID INJURY OCCUR?		22G. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22H. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22I. ACTUAL SIGNATURE EXAMINER'S NAME (Type)	
						Werner U. Spitz, M.D.	
22J. DEPUTY CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		22K. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22L. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		22M. DATE SIGNED	
						10-12-71	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10-14-71		Mt Calvary Cent		All County Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
OCT 13 1971		Robert E. Fisher, M.D.		L. Wilson		1000 Monticello	



1. NAME OF DECEASED (Type or Print) <b>ROBERT QUEEN</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>October</b> Day <b>6</b> Year <b>1971</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>708 N. Carrollton Avenue</b>		3. DATE PRONOUNCED DEAD Month <b>October</b> Day <b>6</b> Year <b>1971</b> Hour <b>6:00 P.</b> M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>69</b>		10. AGE (In years lost birthday) <b>69</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Queen</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
15. MOTHER'S MAIDEN NAME <b>Frances Queen</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>10</b>		18. INFORMANT <b>Thomas Wallace</b>	
19. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>10-12-71</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>October 7, 1971</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-12-71</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mount Airy</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>	
25C. FUNERAL DIRECTOR <b>Ed Wilson</b>		ADDRESS <b>1002 Brantley Ave</b>	

ACADEMY FOND

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">71 9465</span>	
BIRTH NO. <span style="float: right;">71 9465</span>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <span style="float: right;">TUCKER Addie</span>		2. DATE AND HOUR OF DEATH <span style="float: right;">10/8/1971 11:35 P.M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="float: right;">Good Samaritan Hospital</span>		A. STATE <span style="float: right;">Maryland</span>		B. COUNTY <span style="float: right;">909</span>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <span style="float: right;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <span style="float: right;">1813 Emsor St.</span>			
5. SEX <span style="float: right;">F</span>	6. RACE <span style="float: right;">N</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="float: right;">Sept. 8, 1896</span>	9. AGE (In years lost birthday) <span style="float: right;">75</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="float: right;">None</span>		11. BIRTHPLACE (State or foreign country) <span style="float: right;">South Carolina</span>	
13. FATHER'S NAME <span style="float: right;">Richard Murray</span>		14. MOTHER'S MAIDEN NAME <span style="float: right;">Viola Smith</span>		12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">U.S.A.</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) <span style="float: right;">No</span>		16. SOCIAL SECURITY NO. <span style="float: right;">218-55-1327</span>		17. INFORMANT <span style="float: right;">Long Tom Tucker</span>	
18. <span style="float: right;">4/12/71</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="float: right;">Cerebrovascular Accident.</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="float: right;">12 days</span>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <span style="float: right;">Outersiderotic Cardiovascular Disease</span> DUE TO, OR AS A CONSEQUENCE OF: <span style="float: right;">Disease</span>		<span style="float: right;">unknown</span>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="float: right;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <span style="float: right;">9/24</span> 19 <span style="float: right;">71</span> to <span style="float: right;">10/8</span> 19 <span style="float: right;">71</span> that <del>the</del> (we) last saw the deceased alive on <span style="float: right;">10/8</span> 19 <span style="float: right;">71</span> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> (did) (did not) view the body after death.					
23A. SIGNATURE <span style="float: right;">[Signature]</span>		23B. DATE SIGNED <span style="float: right;">10/8/71</span>		23C. PHYSICIAN'S NAME (Type) <span style="float: right;">JOSE MARTINEZ MD</span>	
23D. ADDRESS <span style="float: right;">101, Medical Arts Bldg.</span>		24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">10-11-71</span>	
24C. NAME OF CEMETERY or CREMATORY <span style="float: right;">Mt. Auburn Cem.</span>		24D. LOCATION (City, town, or county) (State) <span style="float: right;">Baltimore Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">OCT 13 1971</span>	
25B. NAME OF REGISTRAR <span style="float: right;">Robert E. Taylor, MD.</span>		25C. FUNERAL DIRECTOR <span style="float: right;">Edw. O. Wilson</span>		25D. ADDRESS <span style="float: right;">1000 Broadway Ave.</span>	



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Clay O. Wilson 1000 Enser 21

10-11-51

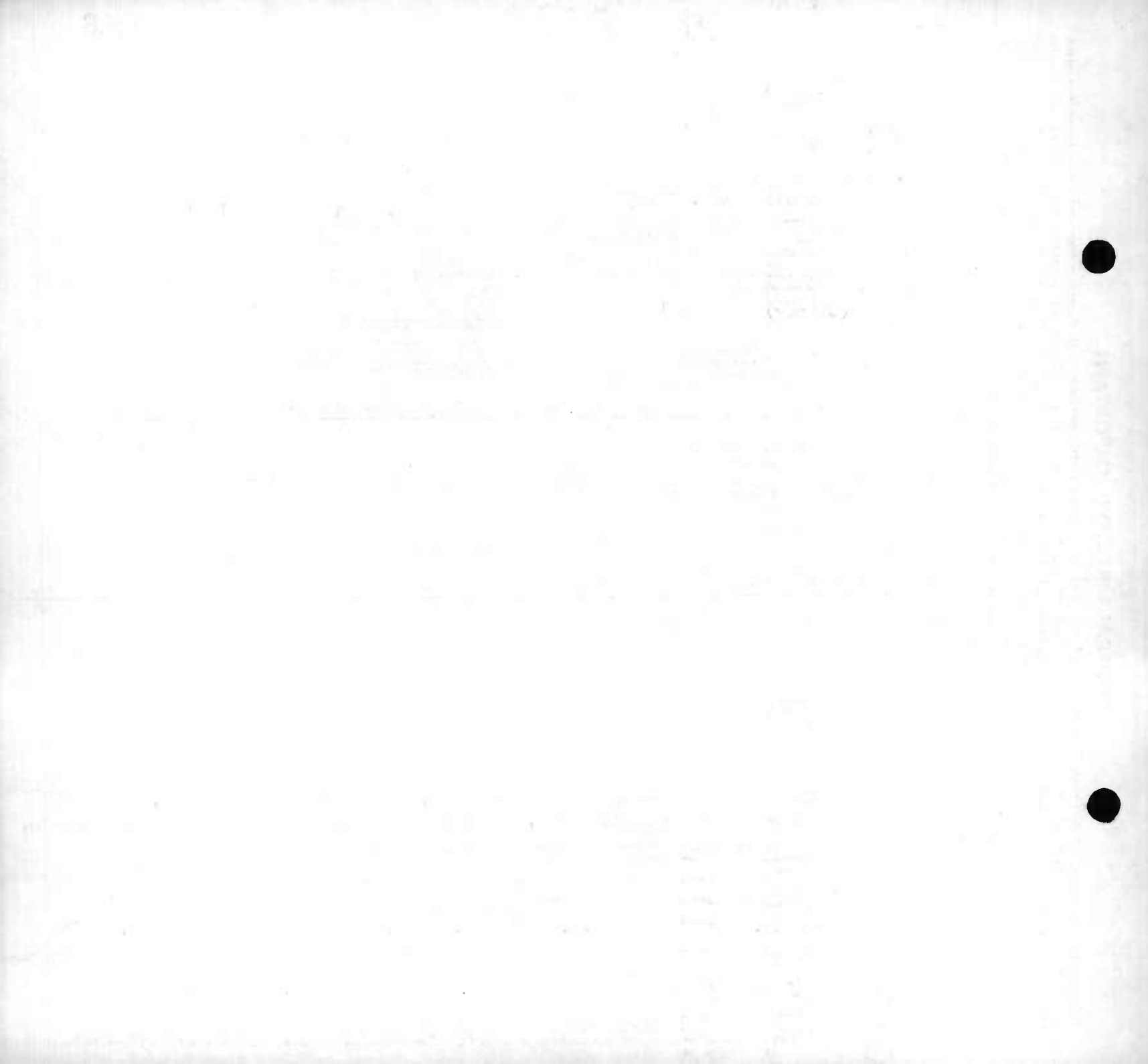
10-11-51



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>H-220</u> <u>71</u> <u>9466</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71</u> <u>9466</u>	
1. NAME OF DECEASED (Type or Print) <u>Hughes, William</u>				2. DATE AND HOUR OF DEATH <u>10/8/71</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Agnes Hospital</u> <u>40 Wilkens and Caton Ave. 21229</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>503 N. Collington Ave 21231</u>			
5. SEX <u>male</u>	6. RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/4/00</u>	9. AGE (in years last birthday) <u>71</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bishop (Clergy)</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Batter Murphy</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>229-22-938</u>		17. INFORMANT <u>Carey Hughes Same</u>			
18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Cerebrovascular Accident Hemorrhage</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Heart Disease</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>October 8, 1971</u> to <u>October 8, 1971</u> that (I) (we) last saw the deceased alive on <u>October 8, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Donato Q. Vargas</u>				23B. DATE SIGNED <u>10-8-71</u>		23C. PHYSICIAN'S NAME (Type) <u>Donato, Vargas</u> M.D.	
				23D. ADDRESS <u>St. Agnes Hospital 900 Caton Ave.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>10-12-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mount Carmel</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Faber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Edward J. Brantly Jr.</u>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H. 543 71 9467		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9467	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) William Hamilton		2. DATE AND HOUR OF DEATH 10/10/71 19:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1703		5. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hosp.		E. STREET AND NUMBER 709 Dolphin St.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-23-80	9. AGE (In years last birthday) 91	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Willis Hamilton		14. MOTHER'S MAIDEN NAME Janice Carter	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) M		16. SOCIAL SECURITY NO. 212-01-0376		17. INFORMANT Abra Hamilton 709 Dolphin St.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: metastatic gastric ca		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months	
19A. DATE OF OPERATION 8/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ca of stomach		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-9 1971 to 10/10 1971 that (I) (we) last saw the deceased alive on 10/9 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John Singer		23B. DATE SIGNED 10/10/71		23C. PHYSICIAN'S NAME (Type) J. SINGER	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10-13-71		24C. NAME OF CEMETERY OR CREMATORY Not known	
24D. LOCATION Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. OCT 13 1971		25B. NAME OF REGISTRAR B. Wilson	
25C. FUNERAL DIRECTOR 1000 Brantley Rd		25D. ADDRESS		25E. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

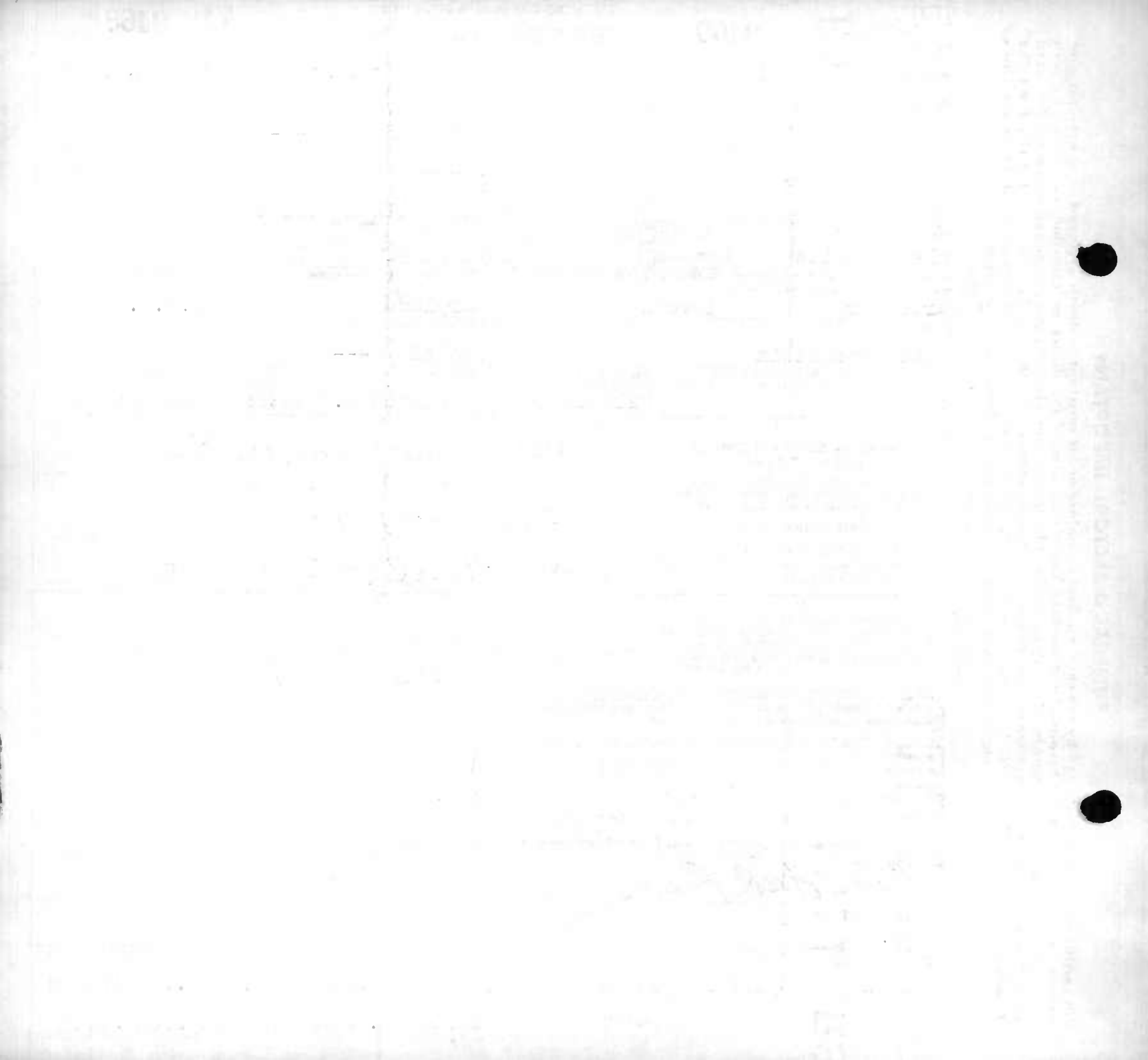
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">71 9468</span>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Lucille Anderson</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">Oct. 10 - 71</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <span style="font-size: 1.2em;">Maryland General Hosp.</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">1601</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Balt.</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">1017 Edmonson Ave Balt 23 md.</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">Black</span>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">10/2/14</span>	<b>9. AGE</b> (in years, last birthday) <span style="font-size: 1.2em;">57</span> If Under 1 Yr. Months Days If Under 24 Hrs. Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Housewife</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">North Carolina</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">John Cobb</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Bernice Kelly</span>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">42-18-4894</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Norene Wheeler</span>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center;">II</div> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>		<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <span style="font-size: 1.2em;">lung metastases</span> (B) <span style="font-size: 1.2em;">Carcinoma of the Breast</span> DUE TO, OR AS A CONSEQUENCE OF (C)		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">10-15-71</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">Cancer</span>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">No</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">9/26</span> <b>19</b> <span style="font-size: 1.2em;">71</span> <b>to</b> <span style="font-size: 1.2em;">10/10</span> <b>19</b> <span style="font-size: 1.2em;">71</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">10/10</span> <b>19</b> <span style="font-size: 1.2em;">71</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Michael A Silverman MD</span>		<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">10/10/71</span>		<b>23C. PHYSICIAN'S NAME (Type)</b> <span style="font-size: 1.2em;">Michael A. Silverman MD</span>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">10-15-71</span>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Crown Memorial Park</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Towson Md</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">OCT 13 1971</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Naber, M.D.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">A. D. GILSON</span>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				CERTIFICATE OF DEATH		REG. NO. <span style="font-size: 1.2em;">71</span> <span style="font-size: 1.2em;">9469</span>	
BIRTH NO. <span style="font-size: 1.5em;">R-252</span> <span style="font-size: 1.5em;">9469</span>				1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Morris Rosenstein</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">10-8-71</span> <span style="font-size: 1.2em;">9:45</span> P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">Mercy Hospital</span> <span style="font-size: 1.5em;">37</span>				A. STATE <span style="font-size: 1.2em;">Maryland</span>		B. COUNTY <span style="font-size: 1.5em;">501</span>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <span style="font-size: 1.2em;">1053 Hillen Street</span>			
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">10/20/1892</span>		9. AGE (in years last birthday) <span style="font-size: 1.2em;">78</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Bartender</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Tavern</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Isaac Rosenstein</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Rachel</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">218 12 8480</span>		17. INFORMANT <span style="font-size: 1.2em;">Constance A. Pastore</span>		ADDRESS <span style="font-size: 1.2em;">1818 Yakona R</span>	
18. <span style="font-size: 1.5em;">512 X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">myocardial infarction</span> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) PNEUMOTHORAX (C) pos. Renal failure acute</span>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <span style="font-size: 1.2em;">10-8-71</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <span style="font-size: 1.2em;">Yes</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">10-8-71</span> 19 <span style="font-size: 1.2em;">10-8-</span> 1971 to <span style="font-size: 1.2em;">10-8-</span> 1971 and that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">10-8-</span> 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.5em;">[Signature]</span>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Dr. Lee</span>				23D. ADDRESS <span style="font-size: 1.2em;">[Address]</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">10/13/71</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Glen Haven Memorial</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Anne Arundel Co., Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">OCT 13 1971</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. [Signature]</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">William E. Johnson</span> ADDRESS <span style="font-size: 1.2em;">8521 Loch Raven</span>			





1

B-214 71 9470

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 9470

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>George Busfield</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>10</b> Day <b>11</b> Year <b>71</b> Estimated <input type="checkbox"/> <b>10</b> <b>11</b> <b>71</b> Hour <b>7:40 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>5958 Daywalt Ave., Apt. L</b>		3. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>11</b> Year <b>71</b> Hour <b>7:40 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>N. Wildwood</b>	
9. DATE OF BIRTH <b>Aug. 19, 1903</b>		10. AGE (In years last birthday) <b>68</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Busfield</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Fletcher</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Investigator</b>		16. KIND OF BUSINESS OR INDUSTRY <b>State of N.J.</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		18. SOCIAL SECURITY NO. <b>138 30 1494</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		20. CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Arteriosclerotic cardiovascular disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
23A. DATE OF OPERATION <b>10/12/71</b>		23B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
24A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
24C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		24D. HOW DID INJURY OCCUR?	
24E. TIME OF INJURY (APPROX.)		24F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
25. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
26A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		26B. DATE <b>10/12/71</b>	
26C. NAME OF CEMETERY or CREMATORY		26D. LOCATION (City, town, or county) (State) <b>Cape May Co., N.J.</b>	
26E. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1971</b>		26F. NAME OF REGISTRAR <b>Robert E. Salley, M.D.</b>	
26G. FUNERAL DIRECTOR <b>William E. Johnson</b>		26H. ADDRESS <b>8521 Loch Raven Blvd.</b>	

12-11-1918

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ACADEMY OF

12-11-1918

12-11-1918

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9471</u>	
H-430-71 9471		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <u>Holt, Albert Freeman</u>		2. DATE AND HOUR OF DEATH <u>10-9-71</u> <u>2:54</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Md. Gen. Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>29 Chestnut Hill Ave</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4, 1884</u>		9. AGE (In years last birthday) <u>87</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home Improvement</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Oliver E. Holt</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Smith</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-08-6372</u>		17. INFORMANT ADDRESS <u>Louise Shawl 6 Park Mills Ct.</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>15 days</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>9-19</u> 19 <u>71</u> to <u>10-9</u> 19 <u>71</u> that (I) <u>(we)</u> last saw the deceased alive on <u>10-9-</u> 19 <u>71</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Amold B. Alexander MD</u>				23B. DATE SIGNED <u>10-9-11</u>	
23C. PHYSICIAN'S NAME (Type) <u>A.G. Alexander MD</u>		23D. ADDRESS <u>127 Linden Ave Balld Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/12/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor MD</u>		25C. FUNERAL DIRECTOR ADDRESS <u>W. E. Johnson 8521 Loch Raven Blvd.</u>	

COE, W. L.

COE, W. L.

COE, W. L.

COE, W. L.

COE, W. L.

COE, W. L.

COE, W. L.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9472</u>
BIRTH NO. <u>H-252 71 9472</u>		1. NAME OF DECEASED (Type or Print) <u>HASKINS, Robert</u>		
2. DATE AND HOUR OF DEATH <u>10/9/71</u> <u>5:55 p. m.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> FULL NAME OF DECEASED <u>ROBERT HASKINS</u> HOSPITAL OR INSTITUTION <u>10-20-71</u> ADDRESS OR LOCATION <u>The Johns Hopkins Hospital</u>		
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>808</u>		5. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
6. STREET AND NUMBER <u>1050 Durham Street</u>		7. SEX <u>Male</u> 8. RACE <u>Negro</u> 9. MARried <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10. B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>Charlotte Court Hse., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Judy Haskins</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>15-05-8392</u>		17. INFORMANT <u>CHART</u> ADDRESS <u>JOHN HOPKINS HOSPITAL</u>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>HEPATIC COMA - Hepatorenal syndrome</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>78 DAYS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>LAENNAIS CIRRHOsis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>MANY YEARS</u> (C) <u>ALCOHOLIC OVERINDULGANCE</u> <u>MANY YEARS</u>				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <u>Oct 2</u> 19 <u>71</u> to <u>Oct 9</u> 19 <u>71</u> and that (2) (we) last saw the deceased alive on <u>Oct 9 5:58 PM</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Michael Kay M.D.</u>		23B. DATE SIGNED <u>10/9/71</u>		23C. PHYSICIAN'S NAME (Type) <u>MICHAEL KAY M.D.</u>
23D. ADDRESS <u>JOHNS HOPKINS HOSP BALT. MD</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		
24B. DATE <u>10-16-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>MOUNT ZION CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>RED HOUSE, VIRGINIA</u>
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>MORTON &amp; DYETT F. H.</u>
ADDRESS <u>1701 LAURENS ST.</u>				

Letter from Jeffress Funeral Home,  
Charlotte Court House, Va. 10-20-71 M.H.

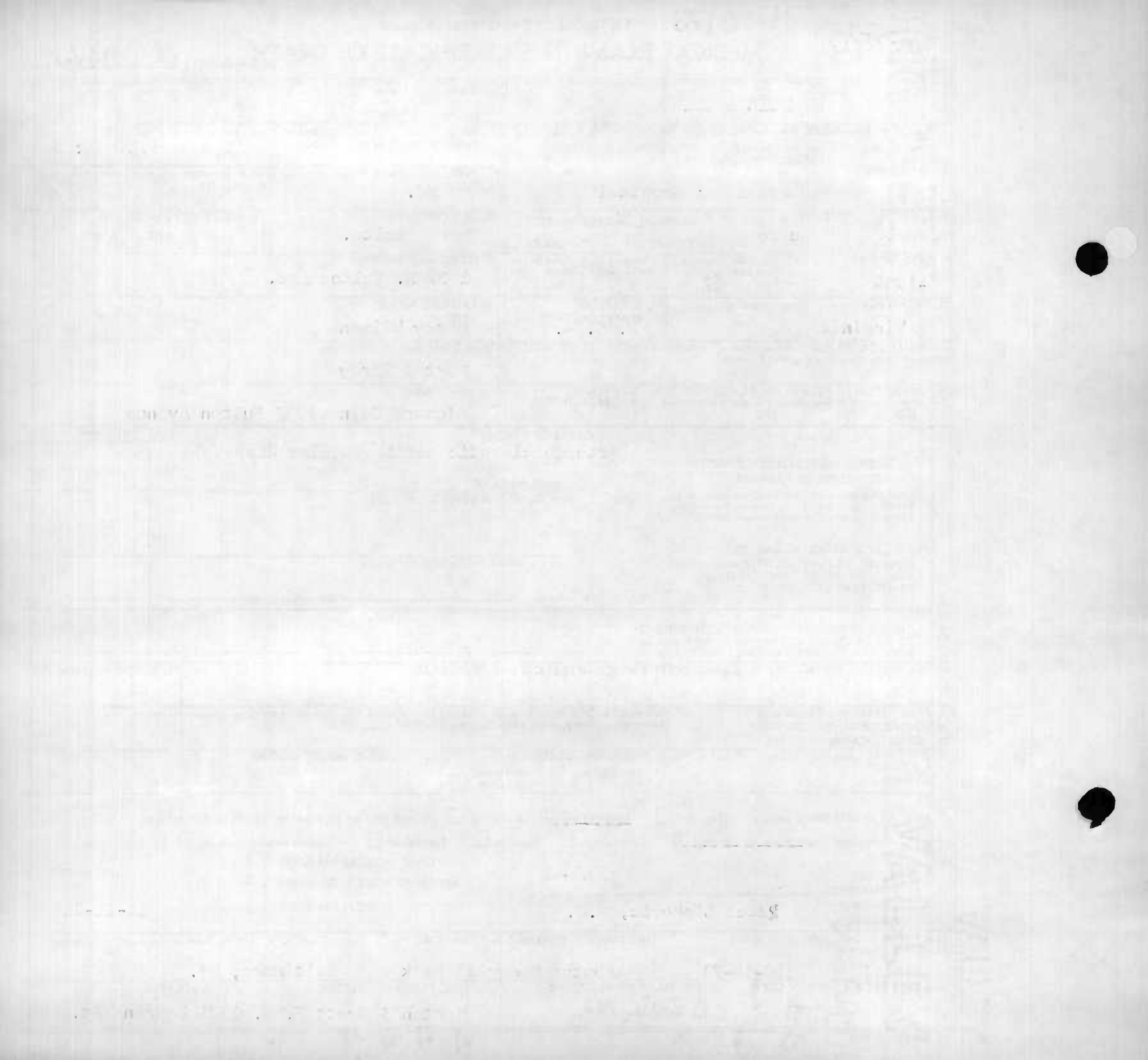
10/20/71  
Mr. & Mrs. J. H. Williams  
1000 1st St. N.E.  
Atlanta, Ga. 30309  
Dear Mr. & Mrs. Williams:  
I am sorry to hear of the death of your son, James H. Williams, Jr. who died on October 15, 1971 at the age of 21 years. We have been informed that he was a member of the United States Marine Corps. Our sympathies are with you and your family at this time of sorrow. We hope that the Lord will comfort you in your grief. If you need any assistance in making arrangements for the funeral, please do not hesitate to call us at (703) 555-1234. We will be glad to help you in any way we can. Sincerely,  
Jeffress Funeral Home  
1000 1st St. N.E.  
Atlanta, Ga. 30309

BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

BIRTH NO.

REG. NO. 71 9473

1. NAME OF DECEASED (Type or Print) <b>MATILDA CAIN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 11 1971 4:55a</b> M.	
6. SEX <b>female</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1603</b>	
9. DATE OF BIRTH <b>6-1-04</b>		10. AGE (In years lost birthday) <b>67</b> If Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF <b>U. S. A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME <b>Harry Wilson</b>		15. MOTHER'S MAIDEN NAME <b>Martha Spray</b>	
18. INFORMANT <b>Richard Cain</b>		ADDRESS <b>1037 Fulton Avenue</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>10-11-71</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-14-71</b>	
24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett F. H.</b>		ADDRESS <b>1701 Laurens St.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9474</u>	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO. <u>D-525 71 9474</u>					
1. NAME OF DECEASED (Type or Print) <u>Major Duncan</u>			2. DATE AND HOUR OF DEATH <u>10/10/71</u> <u>8:30 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital, Inc.</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21215</u>			A. STATE <u>Maryland</u> B. COUNTY <u>1512</u>		
5. SEX <u>Male</u>			6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>2-4-90</u>		9. AGE (In years last birthday) <u>81</u>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-07-7567</u>		17. INFORMANT <u>Rev. Lorenzo Graves</u> ADDRESS <u>3502 Carsdale Avenue</u>	
18. <u>4364 I</u> CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory Failure</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>C.U.A.</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/6/71</u> to <u>10/10/71</u> that (I) (we) last saw the deceased alive on <u>10/10/71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Rayman. F. Allyn</u>					23B. DATE SIGNED <u>10-6-71</u>
23C. PHYSICIAN'S NAME (Type) <u>RAYMAN. I. ALLYN</u>					23D. ADDRESS <u>PROVIDENT</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-14-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>	
24D. LOCATION <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Morton &amp; Dyett F. H.</u> ADDRESS <u>1701 Laurens St.</u>	

3/3/71

Come to Fred's from  
another N. H. (Miller's N. H.)

BALTIMORE CITY HEALTH DEPARTMENT				71 9475			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				71 9475			
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>Lacy G. Coble</b>				2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> Month <b>10</b> Day <b>10</b> Year <b>71</b> Hour <b>5:05A</b> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 705 North Calhoun Street</b>				3. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>10</b> Year <b>71</b> Hour <b>5:05AM</b> M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1602</b>							
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>1-10-1890</b>		10. AGE (In years lost birthday) <b>81</b>		E. STREET AND NUMBER <b>705 N. Calhoun Street</b>			
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Faith Coble</b>			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Moulder Helper</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. Railroad</b>		15. MOTHER'S MAIDEN NAME <b>Mary Foust</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>705-05-5582</b>		18. INFORMANT ADDRESS <b>Mrs. Leana Ferrell 3407 Copley Road</b>			
19. CAUSE OF DEATH <b>185X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Prostate</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  20A. DATE OF OPERATION <b>0</b> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  21. AUTOPSY? (Yes or No) <b>NO</b>							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>10.10.71</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: <b>Werner U. Spitz, M.D.</b> EXAMINER'S NAME (Type)							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-15-1971</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>NUTTER FUNERAL HOME 3035 W. NORTH AVENUE</b>			

1948

1948

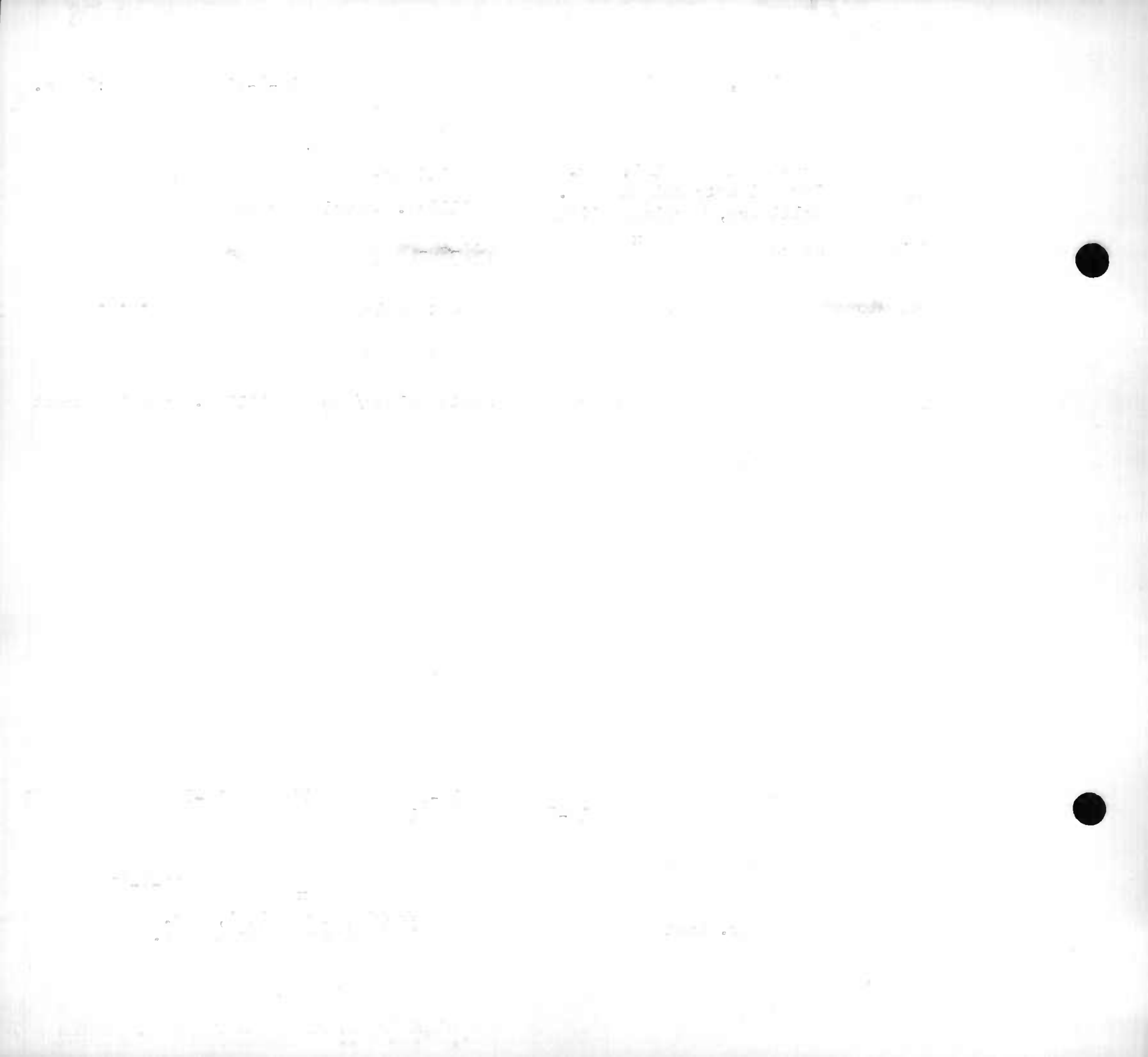
RECEIVED BY BIRMINGHAM

VALLEY VIEW

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.5em;">71 9476</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">W-426 71 9476</span>		<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Walker, Samuel</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">10-7-71 6:30 a.m.</span>	
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <span style="font-size: 1.5em;">39</span> <span style="font-size: 1.2em;">Provident Hospital, Inc. 2600 Liberty Heights Ave. Baltimore, Maryland 21215</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">1601</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">1113 W. Lanvale Street</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">Negro</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">11-18-1892</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">78</span>	<b>10. UNDER 1 Yr.</b> Months Days <b>11. UNDER 24 Hrs.</b> Hours Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Chef Cook</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Pvt. Family</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">West Indies</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>			<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Thomas Walker</span>		
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Catherine ?</span>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">215-05-1777</span>		<b>17. INFORMANT</b> ADDRESS <span style="font-size: 1.2em;">Annie Walker/Spouse 1113 W. Lanvale Street</span>			
<b>18. CAUSE OF DEATH</b>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>(A) IMMEDIATE CAUSE</b> <span style="font-size: 1.2em;">Cardiac arrest; Shock</span> DUE TO, OR AS A CONSEQUENCE OF:  <b>(B)</b> <span style="font-size: 1.2em;">Congestive Heart Failure</span> DUE TO, OR AS A CONSEQUENCE OF:  <b>(C)</b> <span style="font-size: 1.2em;">Arteriosclerotic Cardiovascular Disease</span>		
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">10-7-71</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">No</span>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">10-6 19 71</span> <b>to</b> <span style="font-size: 1.2em;">10-7 19 71</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">10-7 19 71</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">[Signature]</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">11-7-71</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Dr. Loot</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">Provident Hospital, Inc. 2600 Liberty Heights Ave.</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">10-11-71</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Arbutus Memorial Park</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Co. Maryland</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">OCT 13 1971</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. [Signature]</span>		<b>25C. FUNERAL DIRECTOR</b> ADDRESS <span style="font-size: 1.2em;">NUTTER FUNERAL HOME 3035 W. NORTH AVE.</span>			



A450

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71 9477

## BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 9477

1. NAME OF DECEASED (Type or Print) Leroy Allen		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 11 Year 71 Hour 8:15 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital		3. DATE PRONOUNCED DEAD Month 10 Day 11 Year 71 Hour 8:15 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1501			
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH		10. AGE (in years last birthday) 60	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? A	E. STREET AND NUMBER 1420 Prestman Street
13. FATHER'S NAME Jesse Allen		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Lola		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 251-07-9402		18. INFORMANT Mrs Annie Allen, Route 1, Glen Burnie Md.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty alteration of liver DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. DATE OF OPERATION 2	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/17/71	
24C. NAME OF CEMETERY or CREMATORY Cheraw		24D. LOCATION (City, town, or county) (State) South Carolina	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Adolphus Halstead	
25C. FUNERAL DIRECTOR Adolphus Halstead		25D. ADDRESS 1206 W North Ave	



1915

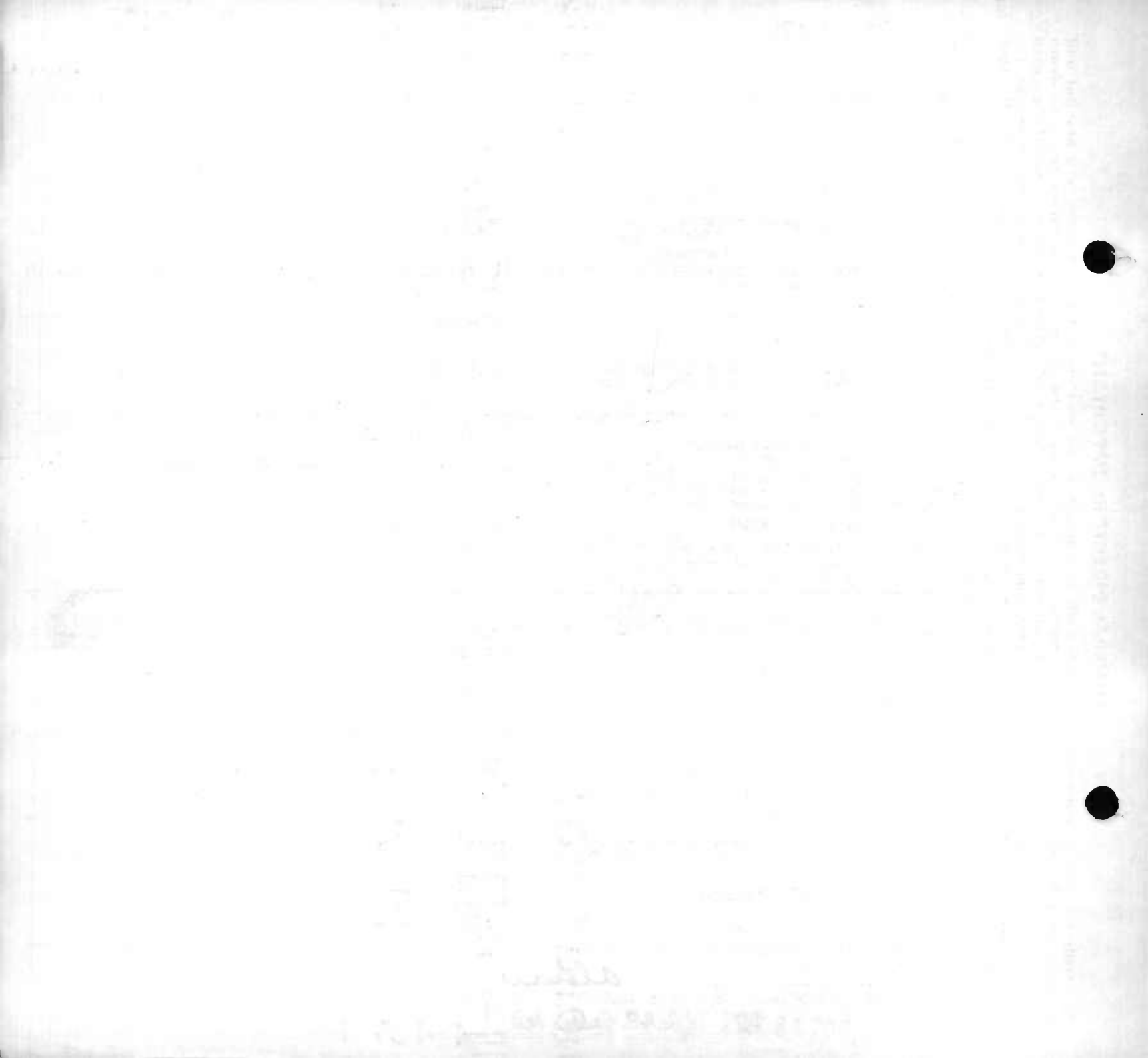
ACADIA



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. <span style="font-size: 1.5em;">71 9478</span>		CERTIFICATE OF DEATH		REG. NO. <span style="font-size: 1.5em;">71 9478</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">John Smith</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">10/3/71 5:30 AM</span>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">Provident Hospital, Baltimore</span>				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">1510</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">4012 MAINE Ave</span>					
5. SEX <span style="font-size: 1.2em;">M.</span>	6. RACE <span style="font-size: 1.2em;">C.</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">10/27/1897</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">89</span>		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">unemployed</span>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">?</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">?</span>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">?</span>				16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">?</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Cole Boarding Home 4012 Maine Ave</span>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  19A. DATE OF OPERATION <span style="font-size: 1.2em;">NONE</span> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <span style="font-size: 1.2em;">Notified</span> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">Cole Boarding Home</span> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <span style="font-size: 1.2em;">4012 MAINE Ave</span> 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <span style="font-size: 1.2em;">9-16-71 ?</span> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> 21F. HOW DID INJURY OCCUR? <span style="font-size: 1.2em;">Fell out of bed ?? unknown</span> 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">9-16-71</span> to <span style="font-size: 1.2em;">10-3-71</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">10-3-71</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				CAUSE OF DEATH <span style="font-size: 1.2em;">ASCVD</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Cardiorespiratory Failure</span> (B) <span style="font-size: 1.2em;">Pneumonia</span> DUE TO, OR AS A CONSEQUENCE OF: (C) <span style="font-size: 1.2em;">Arterio sclerosis</span>  <span style="font-size: 1.2em;">Fracture, Right Femur</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">1 day</span> <span style="font-size: 1.2em;">3 days</span> <span style="font-size: 1.2em;">17 days</span>			
				20A. AUTOPSY? (Yes or No) <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				23A. SIGNATURE <span style="font-size: 1.2em;">Rodolfo Quion md</span> DEGREE <span style="font-size: 1.2em;">M.D.</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">10/3/71</span>			
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Rodolfo L. Quion</span>		23D. ADDRESS <span style="font-size: 1.2em;">Provident Hosp. Baltimore</span>							
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">10/12/71</span>	24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Mt Calvary Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">A A County Md</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">OCT 18 1971</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fisher, MD</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">A Halstead 1206 W north Ave</span>					



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO. 71 9479

1. NAME OF DECEASED (Type or Print) <b>MARIE H SANDERS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3726 Hickory Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 10 1971 1 p</b> M.	
6. SEX <b>female</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>Sept 12 1884</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (in years lost birth day) <b>87</b>		E. STREET AND NUMBER <b>3726 Hickory Ave.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown James Stauffer</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>	
15. MOTHER'S MAIDEN NAME <b>Anna Marie Stauffer</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>562 07 9820</b>		18. INFORMANT ADDRESS <b>Redie Bortle 3033 Elm Avenue</b>	
19. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION <b>10</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10-11-71</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>13 Oct 71</b>	
24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Burgess Funeral Home, Baltimore Maryland</b>		ADDRESS <b>By: [Signature]</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

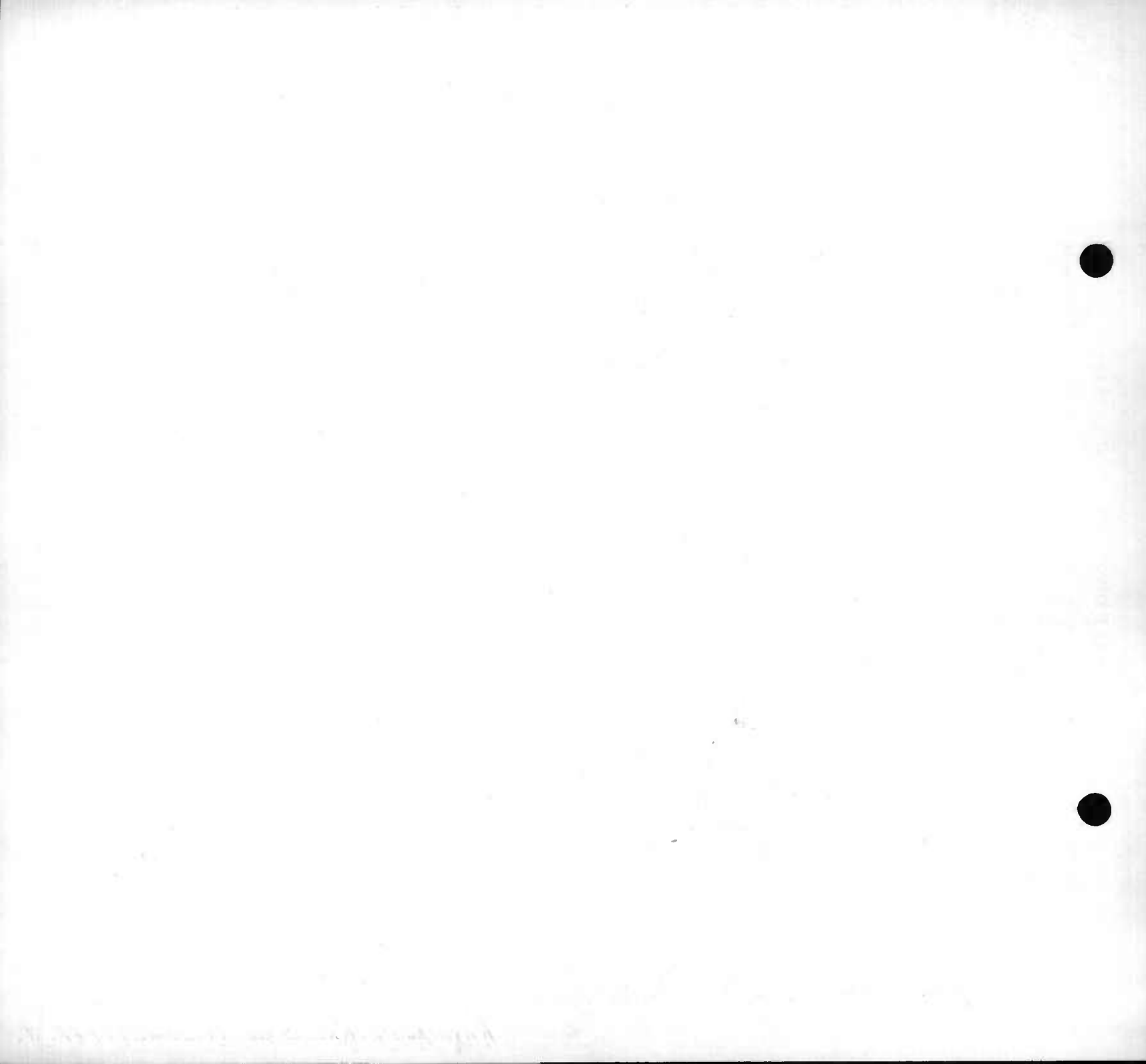
BALTIMORE CITY HEALTH DEPARTMENT				71 9480	
-250 71 9480				REG. NO.	
CERTIFICATE OF DEATH					
BIRTH NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>JACKSON, ETHEL M.</u>			DATE <u>OCT. 7, 1971</u> TIME <u>12:25</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hosp. of Balt. Inc.</u> <u>42</u>			A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>3757 Doldfield Ave.</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-18</u>	9. AGE (In years last birthday) <u>53</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Dunbarton, S.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>George M. Moore, Sr.</u>		
14. MOTHER'S MAIDEN NAME <u>Latinas Hallingguist</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>220-12-6937</u>			17. INFORMANT ADDRESS <u>Miss Barbara McCutcheon-3757 Doldfield Ave.</u>		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Diabetic hyperosmolar syndrome</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Chronic liver disease, diabetes, chronic brain</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>syndrome</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF (INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. (INJURY OCCURRED) While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>SEP. 5</u> 19 <u>71</u> to <u>OCT. 7</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>OCT. 7</u> 19 <u>71</u> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jack Bollock</u> M.D., DEGREE				23B. DATE SIGNED <u>OCT. 7, 1971</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>10-12-71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Mary-Elizabeth Law 802 Madison Avenue</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9481</u>	
BIRTH NO. <u>71 9481</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>JULIA SICKORIA SIKORA-SIKORA</u>			2. DATE AND HOUR OF DEATH <u>10-9-71 8:40 PM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>CHURCH HOME &amp; HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u>		
			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>311 S. MADERIA ST.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-13-97</u>	9. AGE (in years last birthday) <u>74</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETD. CHAR WOMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CHAR</u>	11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA.</u>
13. FATHER'S NAME <u>? ANTHONY SHOBER</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219 03 2737</u>	17. INFORMANT <u>Dr. Sailer, Church Home Hosp.</u>		
18. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(A) IMMEDIATE CAUSE <u>CARDIO RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>INTESTINAL OBSTRUCTION</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) <u>CARCINOMA OF COLON, BLEEDING UNCERTAIN</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>5 days.</u> <u>UNCERTAIN</u>
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <u>10/4/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>—</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>10/4/71</u> 19 <u>71</u> to <u>10/9/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10/9/71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. Mehl</u>			23B. DATE SIGNED <u>10/9/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Ashwin. MEHTA</u>
23D. ADDRESS <u>Church Home Hosp. Ballo. 2123</u>			23E. FUNERAL DIRECTOR <u>RAYMOND KACZOROWSKI</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10/13/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEMETERY</u>	
24D. LOCATION <u>BALTIMORE CO. MD.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>OCT 13 1971</u>		24F. NAME OF REGISTRAR <u>Robert E. Fisher, Jr.</u>	
24G. ADDRESS <u>2525 FLEET ST.</u>		24H. ADDRESS <u>2525 FLEET ST.</u>		24I. ADDRESS <u>2525 FLEET ST.</u>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9482</u>	
BIRTH NO. <u>71 9482</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>William Wallace Spence</u>			2. DATE AND HOUR OF DEATH <u>October 4, 1971 9:35 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland General Hospital</u>			A. STATE <u>Maryland</u> B. COUNTY <u>103</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2510 Fleet Street 21224</u>		
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-8-97</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u>			16. SOCIAL SECURITY NO. <u>213-07-8936</u>		17. INFORMANT <u>MR. LEONARD H. SPENCE</u>
			ADDRESS <u>3109 CHESTNUT AVE</u>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF:				<u>30 min</u>	
(B) <u>CHF</u> DUE TO, OR AS A CONSEQUENCE OF:				<u>2-4 hours</u>	
(C) <u>Adenocarcinoma of Lung</u>				<u>11 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>10/4</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Benign Prostatic Hypertrophy</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 9 1971</u> to <u>October 4 1971</u> that (I) (we) last saw the deceased alive on <u>October 4 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard C. Keown M.D.</u>				23B. DATE SIGNED <u>October 4, 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>Richard C. Keown M.D.</u>				23D. ADDRESS <u>Maryland General Hospital</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10/8/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ST. STANISLAUS CEM.</u>	
				24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u>		25C. FUNERAL DIRECTOR <u>Raymond D. Kaczorowski</u>	
				ADDRESS <u>2525 FLEET ST.</u>	



# FUNERAL DIRECTOR: IMPORTANT

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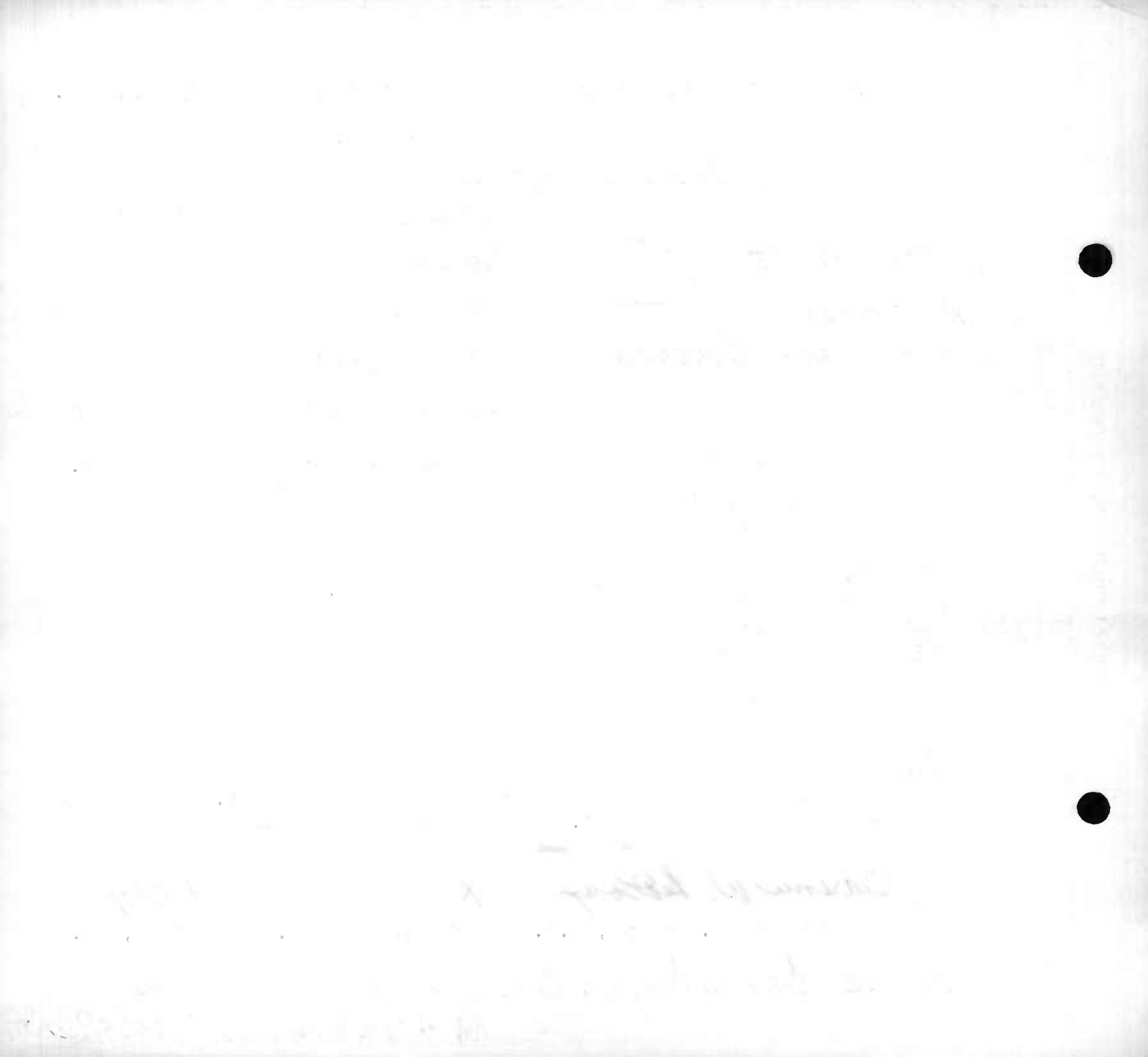
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <span style="font-size: 1.5em;">71 9483</span>				
BIRTH NO. <span style="font-size: 1.5em;">71 9483</span> M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">MRS. CECILIA R. SPENCE</span>					2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">OCTOBER 3 1971   8:00 AM M.</span>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">MARYLAND GENERAL HOSPITAL 48</span>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">BALTIM</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE CITY 21224</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">2510 FLEET STREET</span>				
5. SEX <span style="font-size: 1.2em;">F</span>		6. RACE <span style="font-size: 1.2em;">W</span>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">MARRIED</span>		8. DATE OF BIRTH <span style="font-size: 1.2em;">9-3-98</span>		9. AGE (In years lost birthday) <span style="font-size: 1.2em;">70</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Homemaker</span>					10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">IGNATIUS HEJDA</span>					14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">MARYANNA RAFA</span>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">216-09-5017</span>		17. INFORMANT <span style="font-size: 1.2em;">Chart</span>			ADDRESS		
18. <span style="font-size: 1.5em;">250.71</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Diabetes melitus</span> DUE TO  (B) DUE TO  (C)			INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">10 years</span>	
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <span style="font-size: 1.2em;">9-17</span> <span style="font-size: 1.2em;">1971</span> to <span style="font-size: 1.2em;">10-3</span> <span style="font-size: 1.2em;">1971</span> , that (I) ( <u>we</u> ) last saw the deceased alive on <span style="font-size: 1.2em;">10-3</span> <span style="font-size: 1.2em;">1971</span> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>We</u> ) ( <u>did</u> ) (did not) view the body after death.									
23A. SIGNATURE <span style="font-size: 1.2em;">Sherman Kahan</span> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>								23B. DATE SIGNED <span style="font-size: 1.2em;">10-3-71</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">S. KAHAN</span>				23D. ADDRESS <span style="font-size: 1.2em;">MD GEN HOSP</span>					
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">10/8/71</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">ST. STANISLAUS CEM.</span>			24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE MD.</span>		
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">OCT 13 1971</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>			25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Raymond Lokaczowski 2525 Fleet St.</span>				



# FUNERAL DIRECTOR: IMPORTANT

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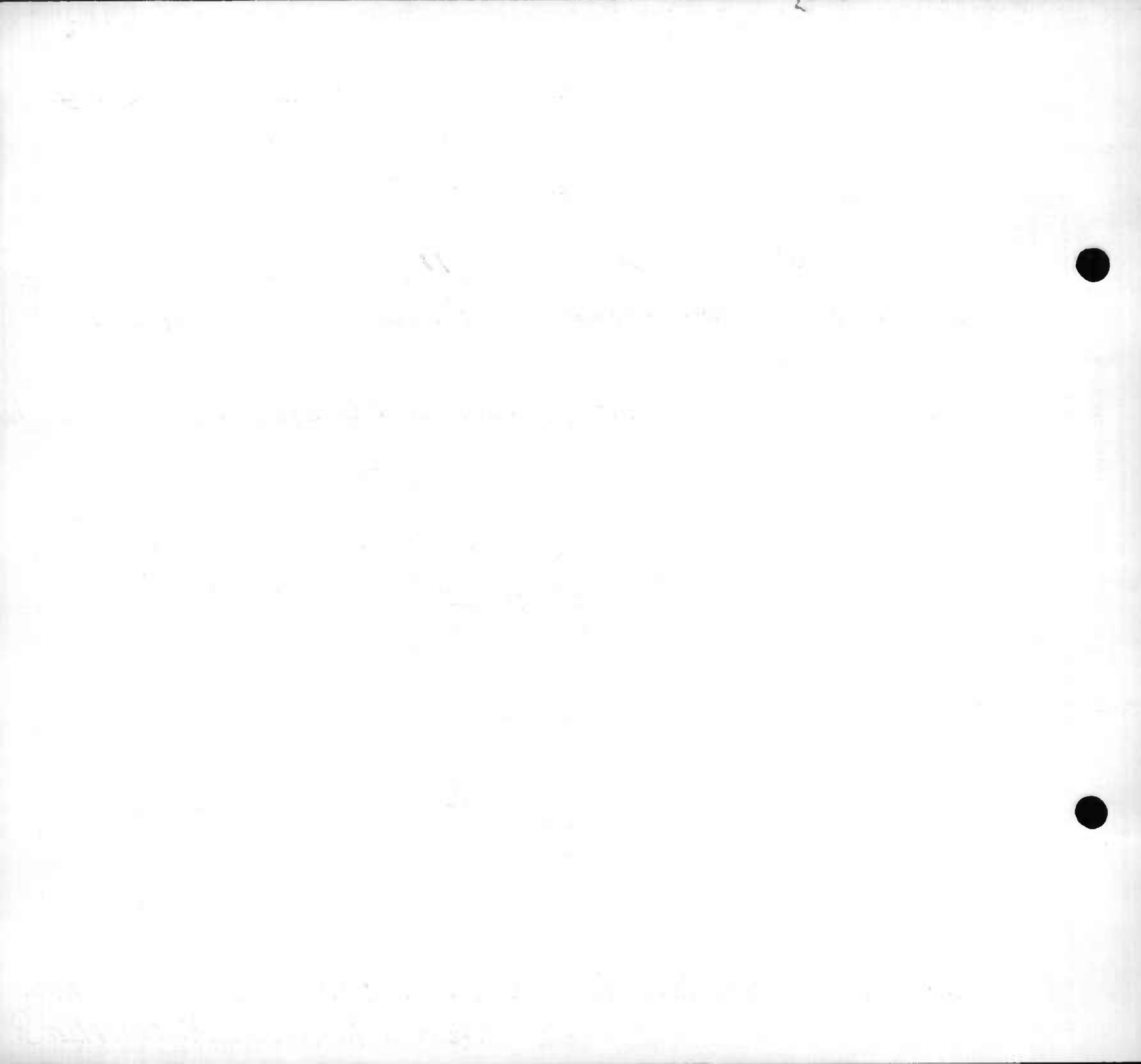
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9484</u>	
BIRTH NO. <u>71 9484</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>LAURA E. GARMAN</u>			2. DATE AND HOUR OF DEATH <u>OCTOBER 6, 1971 1:00 A. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>103</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>504 S. BELNORD AVE.</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>504 S. BELNORD AVE.</u>					
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 30, 1902</u>	9. AGE (In years last birthday) <u>68 YRS</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) <u>HOMEMAKER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>RHEIMHARD BERENDS</u>			14. MOTHER'S MAIDEN NAME <u>MARY NAGLE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. JOHN H. GARMAN</u>
					ADDRESS <u>504 S. BELNORD AVE.</u>
18. <u>412.31</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Heart Disease</u>			2 yrs.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Disease</u>		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 4</u> 19 <u>66</u> to <u>Oct. 6</u> 19 <u>71</u> that (I) ( <del>we</del> ) last saw the deceased alive on <u>Sept. 15</u> 19 <u>71</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>Clarence W. LeDoux</u>				23B. DATE SIGNED <u>10/9/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Clarence W. LeDoux, M.D.</u>				23D. ADDRESS <u>3023 Eastern Ave. Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>OCT. 9, 1971</u>		24C. NAME OF CEMETERY or CREMATORY <u>OAKLAWN CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE M.D.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Talbot, M.D.</u>		25C. FUNERAL DIRECTOR <u>RAYMOND LOKACZOROWSKI</u>	
				ADDRESS <u>2525 FLEET ST.</u>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 9485	
CERTIFICATE OF DEATH					
BIRTH NO. 71 9485					
1. NAME OF DECEASED (Type or Print) BRZOSTEK FRANK J.		2. DATE AND HOUR OF DEATH Oct 4/71 6:55A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME & HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND 103 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 613 S. MONTFORD AVE			
5. SEX M	6. RACE AU. W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/88	9. AGE (in years last birthday) 83	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LONGSHORE		10B. KIND OF BUSINESS OR INDUSTRY MARITIME		11. BIRTHPLACE (State or foreign country) POLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-073101		17. INFORMANT ADDRESS Edward BRZOSTEK 613 S. MONTFORD AVE	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Failure Heart arrest (B) UREMIA DUE TO, OR AS A CONSEQUENCE OF: (C) Ca of Prostate & Metastases		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days 6 months	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 10/3/71 19 to 10/4/71 19 that (1) (we) last saw the deceased alive on 10/3/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE T. Sree Ramamurthy		23B. DATE SIGNED 10/4/71		23C. PHYSICIAN'S NAME (Type) T. SREE RAMAMURTHY	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 10/7/71		24C. NAME OF CEMETERY OR CREMATORY Holy ROSARY CEMETERY	
24D. LOCATION BALTIMORE		24E. LOCATION (City, town, or county)		24F. LOCATION (State) MD.	
25A. DATE REC'D BY HEALTH DEPT. OCT 13 1971		25B. NAME OF REGISTRAR Robert E. Tabor, M.D.		25C. FUNERAL DIRECTOR Raymond A. Kaczorowski	
25D. ADDRESS 2525 Fleet St.					

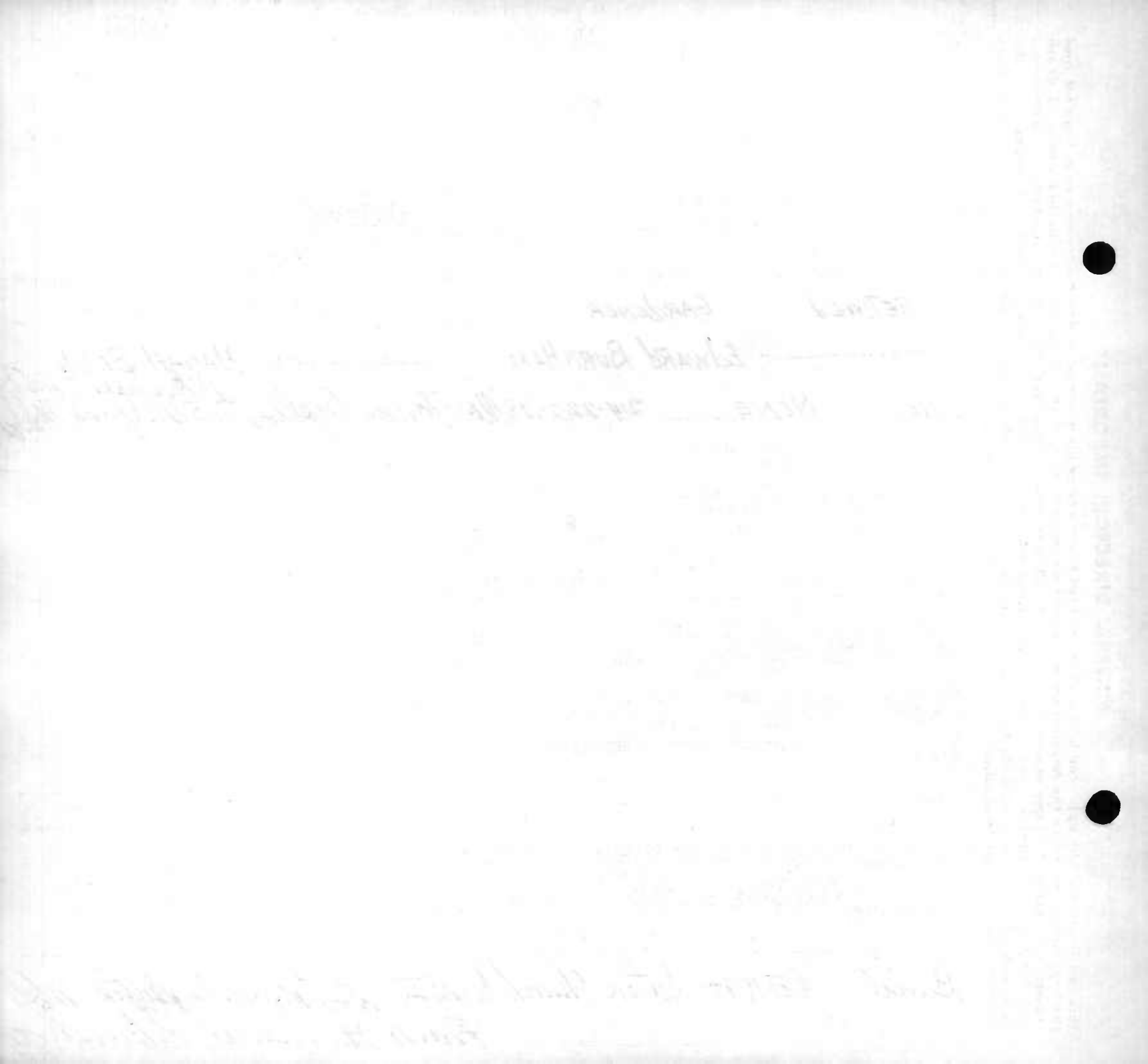




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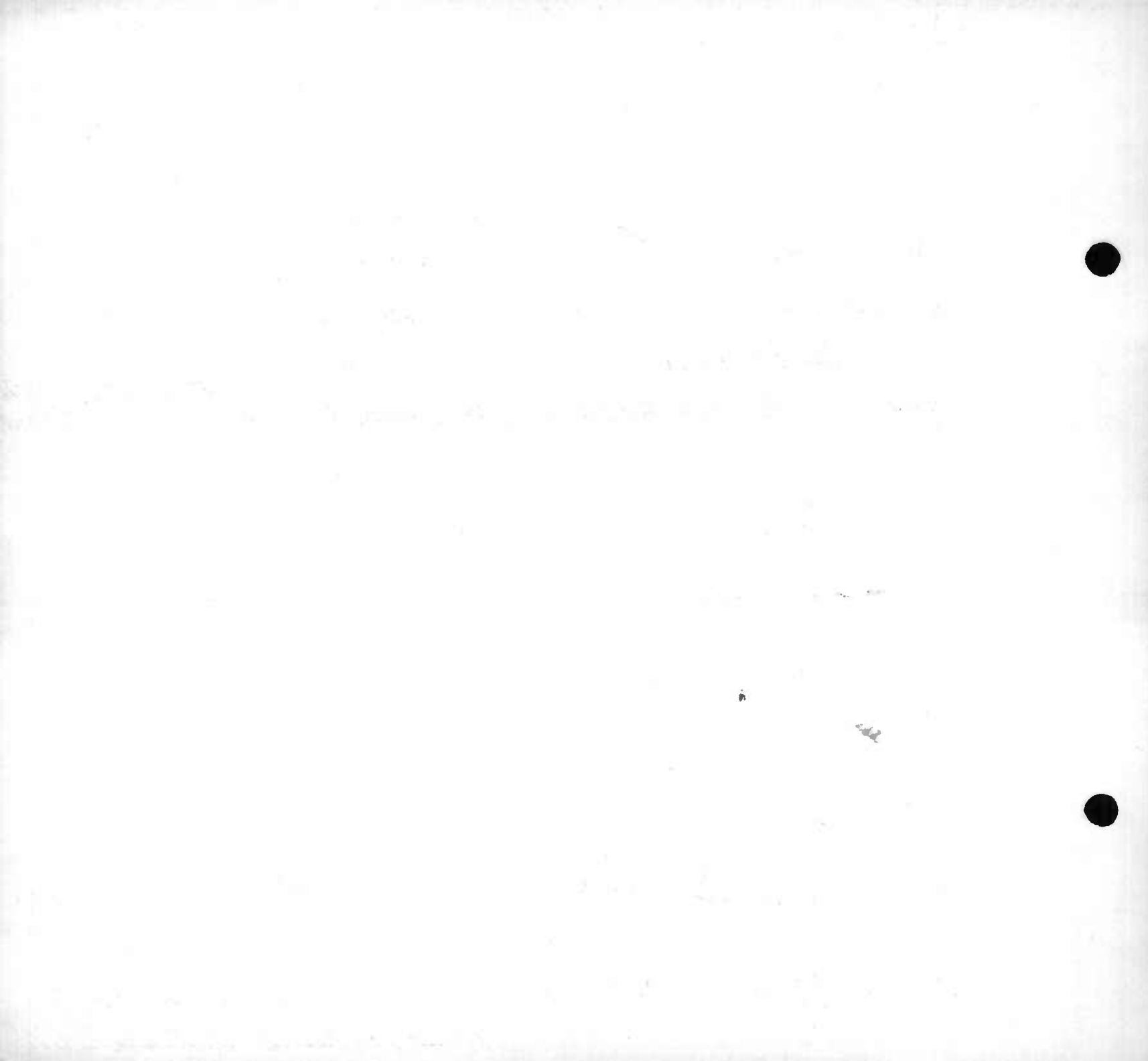
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>71 9486</b>	
B-655		71 9486		X	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BURNHAM CHARLES F		10-8-71 7 <sup>20</sup> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  44 UNION MEMORIAL Hospital				A. STATE CITY OF BALTIMORE	
				B. COUNTY 5300	
C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER RANDALSTOWN Convalescent Center					
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09-8-85	9. AGE (In years last birthday) 86	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY GARDENER		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME JACK AOWA EDWARD BURNHAM			14. MOTHER'S MAIDEN NAME UNKNOWN HANAH BECK		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE			16. SOCIAL SECURITY NO. 214-22-2828		
17. INFORMANT Mrs. Janne Caples, 715 Milford Mill Rd.			ADDRESS Pikesville, Md.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CH F (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  ASCUD. (B) DUE TO, OR AS A CONSEQUENCE OF:  Anemia due to GI Bleeding  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Unknown etiology.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-20-71 19 to 10-8-71 19 that (I) (we) last saw the deceased alive on 10-8-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jairo Ramirez MD				23B. DATE SIGNED 10-8-71	
23C. PHYSICIAN'S NAME (Type) JAIRO RAMIREZ MD				23D. ADDRESS UNION MEMORIAL HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE OCT. 11, 1971		24C. NAME OF CEMETERY or CREMATORY Lutherville, Md.	
24D. LOCATION (City, town, or county) (State) Lutherville, Md.		25A. DATE REC'D BY HEALTH DEPT. OCT 13 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Edward H. Newell, Pikesville, Md.		25D. ADDRESS Pikesville, Md.			



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. J-520 71 9487				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9487	
1. NAME OF DECEASED (Type or Print) LOUIS Edward JONES				2. DATE AND HOUR OF DEATH 10-11-71 9:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MONTEBELLO STATE HOSP. 91				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND 2831 C. CITY OR TOWN CITY Balto D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6602 VINCENT LANE			
5. SEX M.	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-03	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAILMAN		10B. KIND OF BUSINESS OR INDUSTRY U.S. GOVERN.		11. BIRTHPLACE (State or foreign country) Maryland USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Jones UNK				14. MOTHER'S MAIDEN NAME VAK.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1919 to 1934		16. SOCIAL SECURITY NO. 218-37-5601		17. INFORMANT Mrs. Louise S. Jones, 6602 Vincent Lane Apt 105, Baltimore-15208			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION JUNE 1971 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED DIAGNOSTIC 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (A) IMMEDIATE CAUSE CARCINOMA 1° SITE JAW. 71 DUE TO, OR AS A CONSEQUENCE OF: UNDETERMINED 10 MOS. (B) HEPATIC AND LUMBAR DUE TO, OR AS A CONSEQUENCE OF: METASTASIS (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) NO 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from AUG. 6 1971 to Oct. 11 1971 that (I) (we) lost saw the deceased alive on Oct. 11 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jaime F. Casellas M.D. 23C. PHYSICIAN'S NAME (Type) JAIME F. CASELLAS M.D. 23D. ADDRESS 6613 BONNIE RIDGE DRIVE BALTO. MD. 21209				23B. DATE SIGNED Oct. 11, 1971			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct. 14, 1971		24C. NAME of CEMETERY or CREMATORY Crest Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Lukensville, Howard Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 18 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Frank H. Newell		ADDRESS	



M-420 71 9488 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 71 9488  
 BIRTH NO. REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Pearl Miles</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>10 11 71 8:07 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) <b>South Baltimore General Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 11 71 8:07 P. M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Feb. 23 1915</b>		10. AGE (in years lost birthday) <b>56</b>	
11. BIRTH PLACE (State or foreign country) <b>Hanover, Md</b>		12. CITIZEN OF <b>USA</b>	
13. FATHER'S NAME <b>Herbert Edwards</b>		14. MOTHER'S MAIDEN NAME <b>Annie Hall</b>	
15. USUAL OCCUPATION (Give kind of work including most of working life even if retired) <b>Housewife</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Ab Miles - 300 Zepplin Ave</b>	
19. CAUSE OF DEATH <b>412.4 I</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-14-71</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Turnell B. Oden - Balto. Md.</b>		ADDRESS	

ACADEMY OF

ARTS AND LETTERS

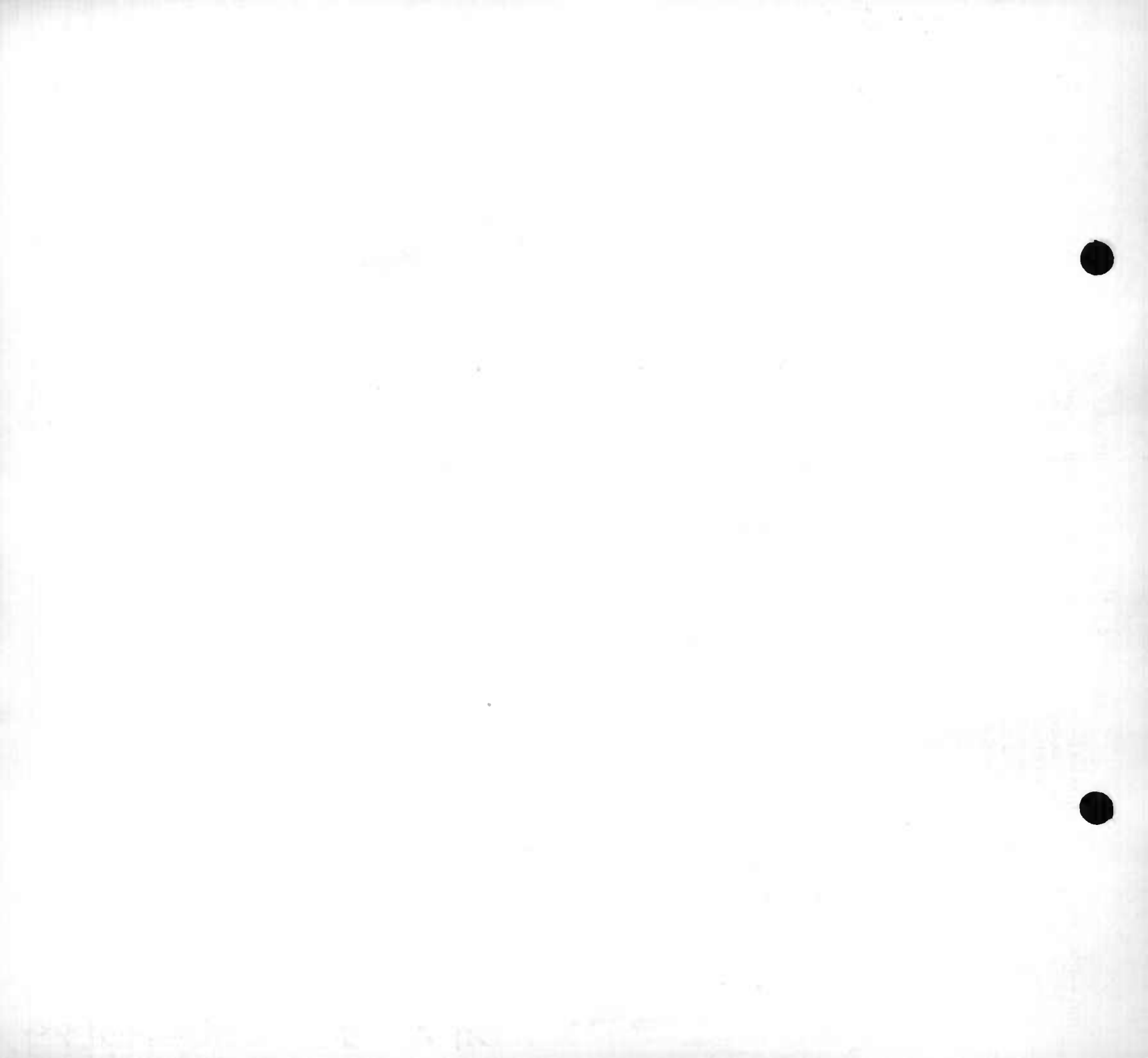
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.


A-534 71 9489		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9489	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ANTLEY, ABRAM AKA AUTLEY		8 <sup>th</sup> Oct. 1971 1.10 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		B. COUNTY 1304	
SINAI HOSPITAL OF BALTIMORE INC.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2215 W. Pitters Ave.		5. SEX m		6. RACE N	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 20, 1894		9. AGE (in years last birthday) 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Auto		11. BIRTHPLACE (State or foreign country) Orangeburg, S. Carolina	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Otes Autley		14. MOTHER'S MAIDEN NAME Sarah Martin	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service)		16. SOCIAL SECURITY NO. 213-03-4439		17. INFORMANT Mrs. C. Vida Autley 2215 W. Pitters Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular accident		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Arteriosclerotic Cardiovascular disease			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 10-2-1971 to 10-8-1971 that (H) (we) last saw the deceased alive on 10-8-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.		23A. SIGNATURE P. PRASAD		23B. DATE SIGNED 10-8-71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS SINAI HOSPITAL, Belvedere Ave 21215.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 10-10-71		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	
24D. LOCATION Westport (Baltimore)		24E. LOCATION (City, town, or county)		24F. LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT. OCT 13 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.A.		25C. FUNERAL DIRECTOR Joseph E. Jones 2215 W. Pitters Ave.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-565 71 9490				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 9490	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>GIANNERINI J. Antonio</b>				2. DATE AND HOUR OF DEATH <b>10-11-71 1140 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION Memorial Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <b>MD.</b>		B. COUNTY <b>City of Baltimore 2632</b>	
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>4807 Althea Ave</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>02-13-86</b>	9. AGE (In years last birthday) <b>85</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN GIANNERINI</b>				14. MOTHER'S MAIDEN NAME <b>MARIA ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217037228</b>		17. INFORMANT <b>Mrs. Marie Onesti 4807 Althea Ave.</b>			
18. <b>412.4</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CVA</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASQUD</b>				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <b>CHF (Congestive heart failure)</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9-26-71</b> 19__ to <b>10-11-71</b> 19__ that (I) (we) last saw the deceased alive on <b>10-11-71</b> 19__ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				23B. DATE SIGNED <b>10-11-71</b>		Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>JAIRO RAMIREZ MD</b>				23D. ADDRESS <b>UNION Memorial Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/15/71</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 12 1971</b>		25B. NAME OF REGISTRAR <b>Robert A. Jaber</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc., Balto. Md. 21214</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

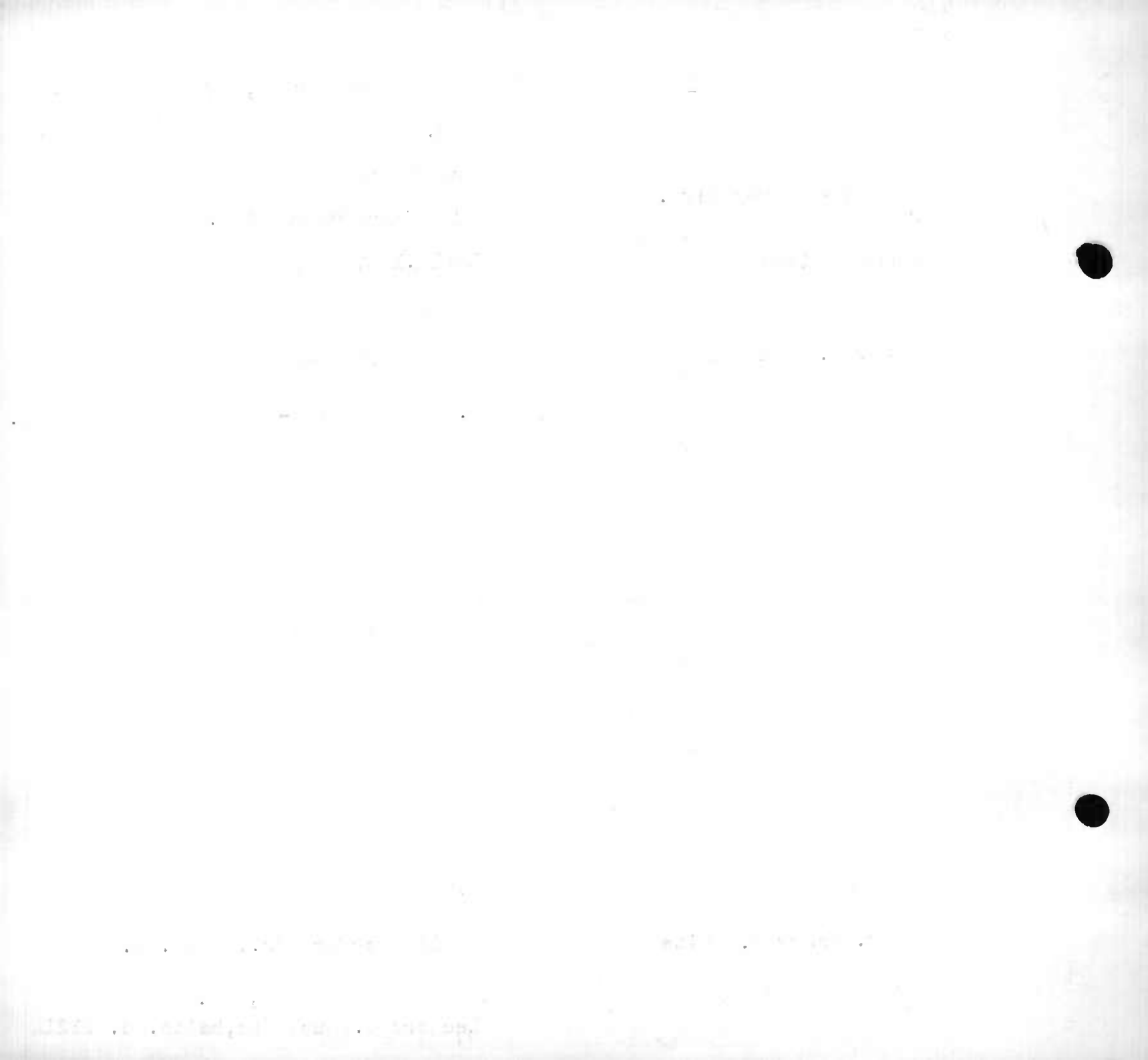
BIRTH NO. <u>M-550 71 9491</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 9491</u>	
1. NAME OF DECEASED (Type or Print) <u>Fr. Thomas J. Monahan</u>				2. DATE AND HOUR OF DEATH <u>October 9, 1971</u> <u>8:11 P.</u> <u>M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 911 W. Lake Avenue</u>				A. STATE <u>Maryland</u>		B. COUNTY <u>2713</u>	
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>911 W. Lake Ave.</u>			
5. SEX <u>male</u>	6. RACE <u>caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/24/1910</u>	9. AGE (in years last birthday) <u>61</u>	11. Under 1 Yr. Months: Days: Hours: Min.	12. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Catholic Priest</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>	
13. FATHER'S NAME <u>John Monahan</u>				14. MOTHER'S MAIDEN NAME <u>Mary Kilbride</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Fr. ORourke 1130 N. Calvert St.</u>	
18. <u>IX</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Carcinoma</u> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Metastatic undifferentiated Carcinoma to G.F. Tract</u>				CAUSE OF DEATH <u>Carcinoma</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Metastatic undifferentiated Carcinoma to G.F. Tract</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>9/20</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/20</u> 19 <u>71</u> to <u>10/9</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>10/9</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Arthur Serpick</u>				23B. DATE SIGNED <u>10/11/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Arthur Serpick</u>	
23D. ADDRESS <u>1114 St. Paul St., Baltimore, Md.</u>				23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/13/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 13 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. - Balto, Md. - 1h</u>		25D. ADDRESS	



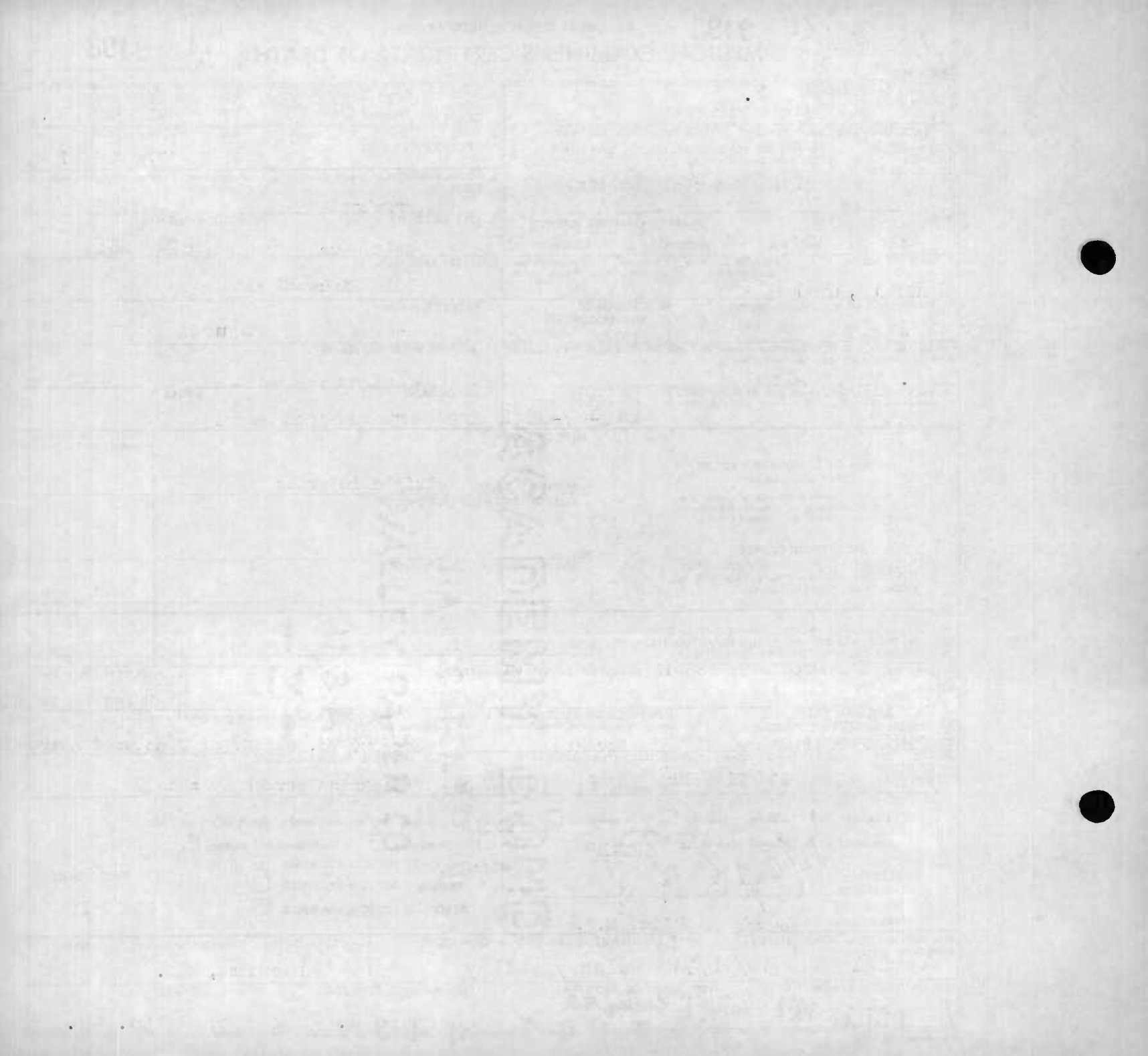
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>T-400 71 9492</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>REG. NO. 71 9492</span> </div>			
1. NAME OF DECEASED (Type or Print) <b>SARA REGINA TOLLE</b>		2. DATE AND HOUR OF DEATH <b>October 11, 1971 11:30 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>6101 Loch Raven Blvd.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2758</b>	
5. SEX <b>Female</b>		6. RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/10/1887</b>	
9. AGE (in years last birthday) <b>83</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Gustav A. Bueschel</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Regina ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212013876</b>	
17. INFORMANT <b>Mr. Walter Tolle-6101 Loch Raven Blvd.</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>October 9, 1971</b> to <b>October 11, 1971</b> and that (I) last saw the deceased alive on <b>October 9, 1971</b> and that (in my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>James E. White MD</b>		23B. DATE SIGNED <b>Oct 11, 1971</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. James E. White</b>		23D. ADDRESS <b>5214 Harford Rd., Balto. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/14/71</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1971</b>		25B. NAME OF REGISTRAR <b>Leonard J. Ruck Inc.</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		ADDRESS <b>Balto. Md. 21214</b>	



BALTIMORE CITY HEALTH DEPARTMENT									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
BIRTH NO. 71 9493									
1. NAME OF DECEASED (Type or Print) <b>E. Louis Marucci</b>					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>10 11 71 89:15A. M.</b>				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 Union Memorial Hospital</b>					3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 11 71 9:15 A.M.</b>				
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2745</b>					6. SEX <b>Male</b> 7. RACE <b>White</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
9. DATE OF BIRTH <b>June 18, 1891</b> 10. AGE (In years lost birthday) <b>80</b> 11. BIRTHPLACE (State or foreign country) <b>Italy</b>					C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					E. STREET AND NUMBER <b>3018 Pinewood Avenue</b>				
13. FATHER'S NAME <b>-</b>					14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Sheet Metal</b>				
15. MOTHER'S MAIDEN NAME <b>Carlotta</b>					16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				
17. SOCIAL SECURITY NO. <b>215-07-3082</b>					18. INFORMANT <b>Mrs Mary Macucci same</b> ADDRESS				
19. <b>E 8141.7</b> CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)									
(A) IMMEDIATE CAUSE <b>Multiple injuries</b> DUE TO, OR AS A CONSEQUENCE OF:									
(B) _____ DUE TO, OR AS A CONSEQUENCE OF:									
(C) _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
20A. DATE OF OPERATION <b>2</b> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED									
21. AUTOPSY? (Yes or No) <b>Yes</b>									
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>									
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Harford Rd. 82' N. of Fleetwood Avenue</b>									
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>10 11 71 9:15A</b> 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>									
22F. HOW DID INJURY OCCUR? <b>Pedestrian struck by auto</b>									
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>10-12-71</b>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> EXAMINER'S NAME (Type)									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> 24B. DATE <b>10/14/71</b> 24C. NAME OF CEMETERY or CREMATORY <b>Dulaney Valley</b> 24D. LOCATION (City, town, or county) (State) <b>Timonium, Md.</b>									
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1971</b> 25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b> 25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc, Balto. Md.</b> ADDRESS									





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>H-13071 9494</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 9494</u>	
1. NAME OF DECEASED (Type or Print) <u>ADA W. HAUPT</u>				2. DATE AND HOUR OF DEATH <u>10/6/71 1130 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Baltimore General</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2403</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1142 Battery Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 19, 1894</u>	9. AGE (in years last birthday) <u>77</u>	10. Under 1 Yr. Months	11. Under 24 Hrs. Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>		11. BIRTHPLACE (State or foreign country) <u>Long Island, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Farber</u>				14. MOTHER'S MAIDEN NAME <u>Mary</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215 07 6785</u>		17. INFORMANT ADDRESS <u>Mrs. Marie Wheeler 1412 Light St.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>410.94-1319</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Probable Myo. Infarction</u> <u>Arteriosclerotic Endocarditis</u> <u>Plenum &amp; Fusion</u> <u>Probable Metastatic Ca of Stomach</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>Years</u> <u>One week</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>10/11/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10:05 PM 10/6/71</u> to <u>11:30 PM 10/6/71</u> that (I) (we) last saw the deceased alive on <u>10:30 PM 1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Rifert Abousy</u>				23B. DATE SIGNED <u>10/7/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Rifert Abousy</u>	
23D. ADDRESS <u>So. Balt. Gen. Hosp.</u>				23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/11/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 13 1971</u>		25B. NAME OF REGISTRAR <u>George J. Gonce</u>		25C. FUNERAL DIRECTOR ADDRESS <u>4001 Ritchie Hwy. Baltimore, Md.</u>			

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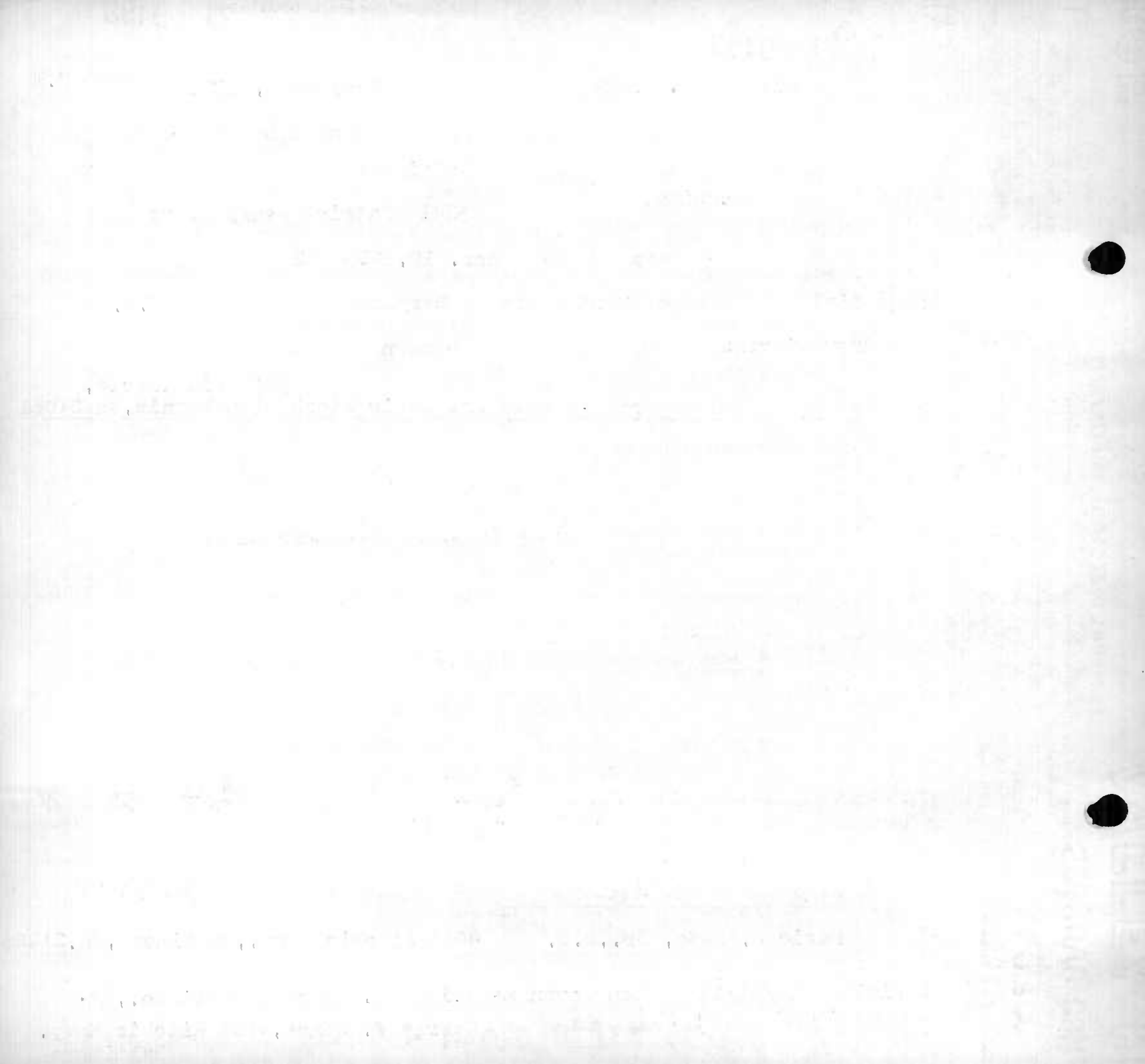
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

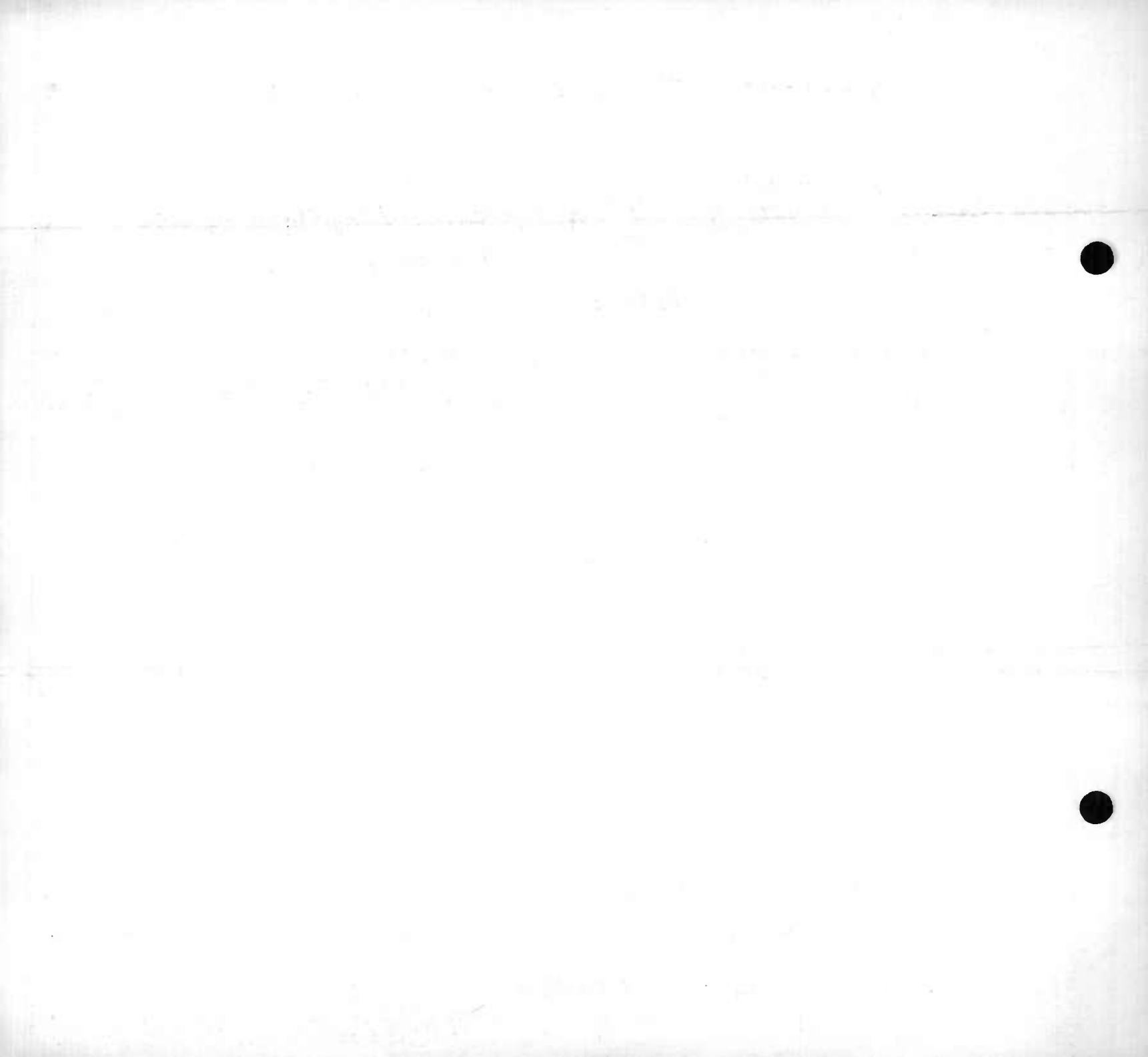
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 9485	
R-360 9485		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MILDRED A. RITTER		October 7, 1971		1:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  43 South Baltimore General Hospital		A. STATE Md			
		B. COUNTY Anne Arundel County 5200			
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 5241 Patrick Henry Drive			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 17, 1909	9. AGE (In years lost birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Girl		10B. KIND OF BUSINESS OR INDUSTRY Department Store		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Andrew Stevens		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216 12 2455		17. INFORMANT ADDRESS 905 Geis Circle, Mrs Doris Stork Glen Burnie, Md 21061	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Myocardial Infarction</i> (B) <i>Hypertensive Cardiovascular Disease</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <i>January 19 68</i> to <i>Sept 20 19 71</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>Sept 30 19 71</i> and that (in my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <del>(did)</del> view the body after death.					
23A. SIGNATURE <i>Mario J. Reda, Sr.</i>				23B. DATE SIGNED 10/7/1971	
23C. PHYSICIAN'S NAME (Type) Mario J. Reda, Sr., M.D.				23D. ADDRESS 4016 Ritchie Hgwy., Baltimore, Md. 21225	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial..		10/11/71		Glen Haven Memorial Pk. Anne Arundel Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 13 1971		<i>Robert E. Fisher, Jr.</i>		George J. Gonc, 4001 Ritchie Hgwy. Baltimore	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

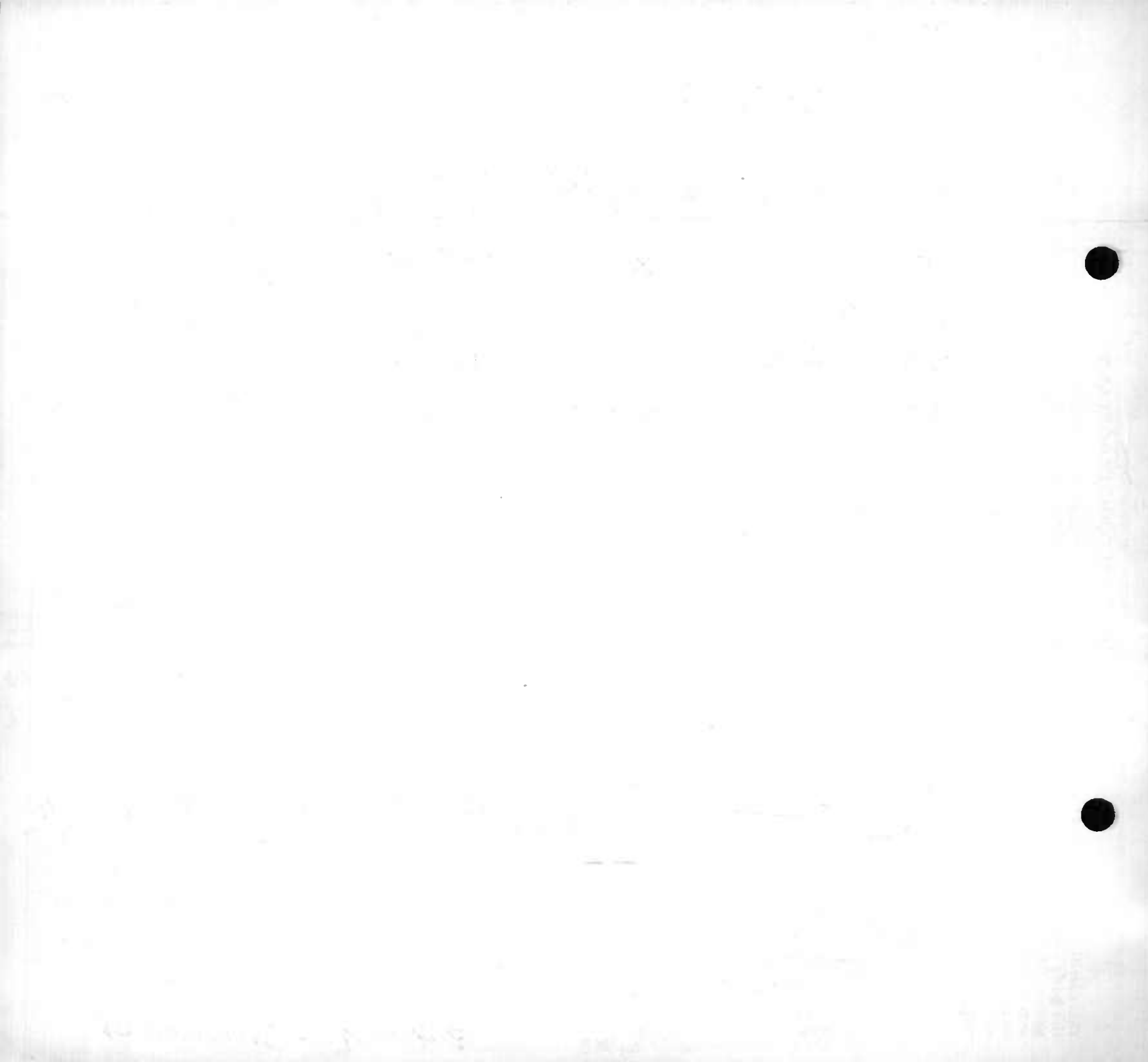
S-163 71 9486		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 71 9486	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SHEPHERD, SHIRLEY ELIZABETH</b>		2. DATE AND HOUR OF DEATH <b>OCT 10 - 1971 11:45 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>USPHS HOSPITAL BALTO. MD.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>VA.</b> B. COUNTY <b>V43</b>		5. CITY OR TOWN <b>LORTON</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX <b>F</b>		7. RACE <b>W</b>		8. DATE OF BIRTH <b>NOV 6/1914</b>	
9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (in years last birthday) <b>56</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HWT.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ARTHUR BAYLISS</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE DENTY</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Marvin E. Shepherd</b> <b>USPHS HOSP RECORDS</b>		ADDRESS <b>Home BALTO. MD.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>203.11</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>PNEUMONIA + SEPSIS</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>CHRONIC MYELOGENOUS LEUKEMIA</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Arthur B. Abbott M.D.</b>		23B. DATE SIGNED <b>OCT 11, 1971</b>		23C. PHYSICIAN'S NAME (Type) <b>ARTHUR B. ABBOTT M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>14 Oct. '71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Pohick Cemetery</b>	
24D. LOCATION <b>Lorton, Virginia</b>		24E. ADDRESS <b>USPHS HOSPITAL BALTO MD.</b>		24F. DATE REC'D BY HEALTH DEPT. <b>OCT 13 1971</b>	
24G. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		24H. CUNNINGHAM DIRECTOR <b>Cunningham-Mountcastle Funeral Home</b>		24I. ADDRESS <b>13318 Occoquan Rd., Woodbridge, Va.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9497</u>	
BIRTH NO. <u>B-452</u>				71 9497	
CERTIFICATE OF DEATH				71 9497	
1. NAME OF DECEASED (Type or Print) <u>Billingsley, Helen</u>			2. DATE AND HOUR OF DEATH <u>10-9-71</u> <u>3:20</u> <u>A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>North Charles General Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1207</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>North Charles General Hospital</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2920 Miles Avenue</u> <u>21211</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-5-98</u>	9. AGE (in years last birthday) <u>73 yrs</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Webster Lee</u>			14. MOTHER'S MAIDEN NAME <u>Preston LEE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>214-24-4885</u>		17. INFORMANT <u>Lee A. Billingsley</u> ADDRESS <u>2608 S. Wymondale Ave</u>
18. <u>4-10-71</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Acute myocardial infarction</u> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Anteroinfarctive Heart Lesion</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Anteroinfarctive Heart Lesion</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u>		
19A. DATE OF OPERATION <u>10-9-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>10-8-71</u> to <u>10-9-71</u> that (H) (we) lost saw the deceased alive on <u>10-9-71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Rufino G. Montenegro M.D.</u> DEGREE				23B. DATE SIGNED <u>October 9, 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>RUFINO G. MONTENEGRO M.D.</u> DEGREE				23D. ADDRESS <u>2827 North Charles Street, Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>10-12-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Saters Church</u>	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION <u>Cockeysville, Baltimore Co. Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 13 1971</u>		25B. NAME OF REGISTRAR <u>Rufino G. Montenegro</u>		25C. FUNERAL DIRECTOR <u>James J. Smith</u> ADDRESS <u>814 N. 36th St</u>	





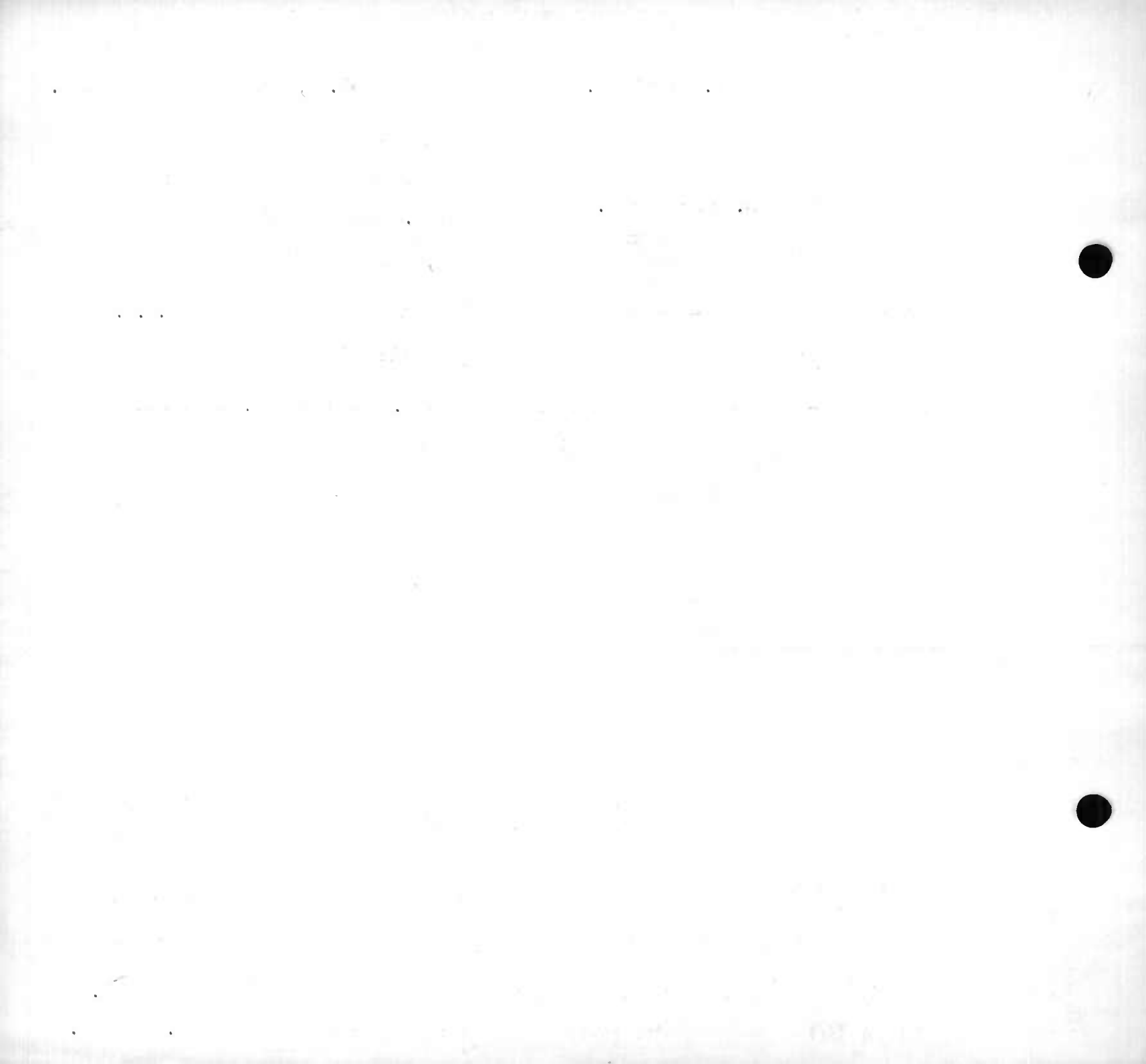
1. NAME OF DECEASED (Type or Print) CHARLES L. SCHLOTTHOBER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour October 12, 1971 1:50 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 4/5/1923		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 48		E. STREET AND NUMBER 1046 Parksley Avenue	
11. BIRTHPLACE (State or foreign country) Balt. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles L. Schlottkofer, Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baltimore	
15. MOTHER'S MAIDEN NAME Margaret Torwood		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes No	
17. SOCIAL SECURITY NO. Mr. M. H.		18. INFORMANT ADDRESS Mary Schlottkofer 1046 Parksley Ave	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) NO			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED: 10/13/71 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/16/71	
24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		24D. LOCATION (City, town, or county) (State) Balt. Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 14 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR John J. Conway, Sr. Inc.		ADDRESS 901 Hollins St. Balt. Md. 21223	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 9499</u>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>George L. Keefe Sr.</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>Oct. 9, 1971</u> <span style="float: right;"><u>2 A.</u></span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>43 South Balto. General Hosp.</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2404</u> <b>C. CITY OR TOWN</b> <u>Baltimore</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>125 E. Barney Street</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>May 5, 1902</u>	<b>9. AGE</b> (In years last birthday) <u>69</u>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>unknown</u>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>unknown</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>-----</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>John Keefe</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Catherine Hull</u>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>unknown</u>		<b>17. INFORMANT</b> <u>Stelle J. Keefe</u> <b>ADDRESS</b> <u>125 E. Barney Street</u>			
<b>18. CAUSE OF DEATH</b>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Arterio-sclerotic cardiovascular disease</u> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>-----</u>					
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <u>-----</u>					
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <u>-----</u>		<b>20A. AUTOPSY?</b> (Yes or No) <u>-----</u>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <u>-----</u>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-----</u>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <u>-----</u>			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.) <u>-----</u>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b> <u>-----</u>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>June 1969</u> <b>to</b> <u>Oct. 9, 1971</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Sept. 10, 1971</u> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>[Signature]</u>				<b>23B. DATE SIGNED</b> <u>10/11/71</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>RICARDO LOZADA</u>				<b>23D. ADDRESS</b> <u>1228 S. Chesapeake St. Baltimore, Md.</u>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>24B. DATE</b> <u>10/12/71</u>		<b>24C. NAME of CEMETERY or CREMATORY</b> <u>Glen Haven Cemetery</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Glen Burnie Md.</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>OCT 14 1971</u>			
<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Taylor, M.D.</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Mc Guffy Funeral Home 130 E. Fort Ave.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 9500</u>	
BIRTH NO. <u>B-65071 9500</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Catherine A. Bryan</u>			2. DATE AND HOUR OF DEATH <u>October 9, 1971</u>   <u>7:30 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> <u>4802 West Parkway</u> <u>Baltimore, Md. - 21229.</u>			A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> <u>2834</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Female</u> 6. RACE <u>Caucasian</u>			E. STREET AND NUMBER <u>4802 West Parkway Balto., Md. 21229</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			B. DATE OF BIRTH <u>Sept. 18, 1908</u> <u>63</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		9. AGE (In years last birthday) <u>63</u>
10B. KIND OF BUSINESS OR INDUSTRY <u>Life Ins. Co.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>James E. Bryan</u>			14. MOTHER'S MAIDEN NAME <u>Ida M. Crook</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>---</u>			16. SOCIAL SECURITY NO. <u>216-03-4657</u>		
17. INFORMANT <u>Miss M. Gertrude Bryan</u>			ADDRESS <u>4802 West Parkway</u> <u>2-21229</u> <u>Balto., Md. -</u>		
18. <u>199.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>metastatic Carcinoma</u> <u>10 Years</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>01/1961</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1961 to Oct 9 1971</u> that (I) (we) last saw the deceased alive on <u>Oct 9 1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>L. A. Lally</u>			23B. DATE SIGNED <u>Oct 11 1971</u>		
23C. PHYSICIAN'S NAME (Type) <u>L. A. LALLY</u>			23D. ADDRESS <u>ROLLING Rd + Edmondson AVE</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/13/71</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 14 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Hays, Jr.</u>		25C. FUNERAL DIRECTOR <u>Sterling Funeral Estate</u> <u>736 Edmondson Ave.</u> <u>Catonsville, Md. 21228</u>	

